

REVIEW OF SECLUSION, RESTRAINT AND OBSERVATION

**of consumers with a mental illness in NSW
Health facilities**

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About One Door Mental Health

One Door is a specialist mental health recovery organisation, with over 31 years of history, committed to improving access to services and the circumstances of people living with severe and complex mental illness.

One Door delivers trauma-informed recovery-oriented psychosocial support programs for carers and consumers. We provide NDIS services, psychosocial community mental health programs such as Personal Helpers and Mentors program (PHaMs), Partners in Recovery (PIR) and Day to Day Living (D2DL), specialist mental health Disability Employment Services (DES), care coordination, housing, clinical and peer supported services. Each year, 10 000 people, across 33 sites in NSW and ACT, access our services.

One Door delivers services and coordinates community psychosocial care for people across silos of sectors, funding and policy through the building of relationships and trust with other providers, funding bodies and most importantly, individuals and the communities they live in.

Who are we?

31

31 years of serving people with a mental illness and their carers

320

320 staff members



92% job satisfaction

400

More than 400 active volunteer workers



74% of staff have lived experience as a consumer or carer



More than 10,000 people accessed our services in the last 12 months



More than 6,000 outreach calls made

Executive Summary

One Door Mental Health welcomes the Review of Seclusion, Restraint and Observation of consumers with a mental illness in NSW mental health facilities. This submission is intended to provide insight based on One Door Mental Health's experience and of mental health consumers associated with One Door.

Seclusion and restraint events can be severely psychologically and physically traumatic, particularly for those with a history of physical or psychological trauma. Seclusion and restraint events also pose a rigorous challenge to the legal rights, dignity and self-respect of people with mental illness. Seclusion and restraint events should be minimised to the greatest extent possible, if not eliminated.

One Door generally appreciates the efforts made in NSW to significantly reduce seclusion and restraint in NSW health facilities. However, improvements to the existing law, policy and reporting governing seclusion and restraint will bring NSW in line with international best practice and national standards.

Recent media attention and the empirical feedback of mental health consumers both suggest that the mental health system may not, in practice, be achieving legislated and policy benchmarks. This may be due to a failure of clinical governance and oversight procedures in the mental health system, as well as staff cultures and practice standards un conducive to achieving these policy aims. These failures of oversight and culture are reinforced by a system that does not adequately, independently and transparently report on seclusion and restraint rates and incidences.

To address these issues One Door recommends:

Reporting of more extensive data sets should be made available to the Mental Health Commission of NSW for preparation of an annual report on seclusion, restraint and observation in NSW mental health units.

Data collection should encourage peer-to-peer benchmarking to drive reduction in seclusion and restraint events.

Seclusion and restraint targets should be set in consultation with the Mental Health Commission of NSW and the Chief Psychiatrist.

Each mental health unit should implement a seclusion and restraint reduction plan which should be provided to the Mental Health Commission of NSW. This plan should be aimed at creating a collaborative non-punitive environment to facilitate the reduction of the use of seclusion and restraint in the approved centre. Elements of the plan should also include:

- Standing item on the agenda of multidisciplinary staff meetings;
- Clinical leadership strategies
- Review of seclusion and physical restraint policies
- Staff training strategies
- Evidence of benchmarking activities
- Evidence of service user and stakeholder consultation in plan development
- Examine the feasibility of establishing psychiatric emergency response teams in each facility with a mental health unit of emergency department.

Similarly, serious improvements to discharge planning and follow-up is needed in order to reduce unplanned readmissions, suicide attempts and completed suicides.

One Door would welcome the opportunity to provide further input towards the NSW Mental Health system.

Sincerely,

A handwritten signature in black ink that reads "Ellen Marks". The signature is written in a cursive, flowing style.

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Seclusion and Restraint in Mental Health Care

Importantly, the use of seclusion and restraint in psychiatric treatment should be one of the most highly regulated and scrutinised practises, yet in NSW there is little independent overview and reporting on policy or practises of seclusion and restraint (and observation). A Cochrane systematic review of seclusion and restraint also found that there was no evidence base for their effectiveness¹.

Involuntarily seclusion is a practice based on protection of the patient and others from harm. Seclusion events can be psychologically and physically traumatic, as well as compromising the freedom of secluded patients, and, as such, should be minimised to the greatest extent possible, if not completely.

Restraint refers to the restriction of an individual's freedom of movement by physical, mechanical or pharmacological means. Chemical restraint is not used in NSW, however, medications used as part of a treatment plan to manage a mental disorder or mental illness are not considered chemical restraint. Furthermore, sedative medication can be used for the management of disturbed behaviour. In NSW, it is One Door's experience that sedation is being used outside of this policy directive as a mechanism of restraint.

Currently, seclusion and restraint are clearly being used as punishment or to fill gaps in staffing rather than a last resort when treatment has failed and there is a question of safety for the individual, staff and others. The current oversight and reporting system does not give rise to transparent or thorough investigation of seclusion and restraint events to gain insight into the abuse of seclusion and restraint practises.

With the recent media focus on the mistreatment and death of Miriam Merten in psychiatric care, the issue of seclusion, restraint and observation in mental health care in NSW has become more visible. Unfortunately there is not, as yet, a great deal of research into this issue.

One Door is not party to the full details of Ms Merten's treatment and therefore the following section is based on what has been publically reported and based on our client's experiences in similar situations. It is unclear at this stage the extent to which the treatment of Ms Merten is endemic to part or whole of the mental health sector. However, in our experience, such treatment of mental health consumers is more common than an isolated incident such as this.

The fundamental issue emerging out of media reporting of the death of Miriam Merten is the use of seclusion and disregard to observation protocols. Ms Merten was secluded in circumstances that not only appear to have been unnecessary given her heavily sedated state, but also circumstances that suggested she needed urgent and personal support and attention. The failure of oversight and effective monitoring of seclusion also stands out. This is not only a breach of international standards (outlined below), but a breach of NSW policy directives.

¹ Sailas EES, Fenton M. Seclusion and restraint for people with serious mental illnesses. Cochrane Database of Systematic Reviews 2000, Issue 1..

The issue of staff mentality also stands out in the treatment of Merten by mental health professionals. Clearly staff were not motivated by policy directives or concern for the best interests of Ms Merten.

Best Practice and Lessons Learned Internationally

International best practice emphasises the minimisation, if not eradication of the use of seclusion and restraint. The United Nation's *Principles For The Protection Of Persons With Mental Illness And The Improvement Of Mental Health Care* states that:

“Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others².”

In Australia, the National Mental Health Seclusion and Restraint Project (NMHSRP) of 2005 involved collaboration between State and Territory Governments and the Commonwealth to reduce and, where possible, eliminate the use of seclusion and restraint in public mental health services. There have also been calls in Australia for the complete abolition of the use of seclusion and restraint in mental health facilities³.

Whilst NSW policy seems well-designed to reduce the use of seclusion and restraint, falling short of eliminating the practice, empirical evidence suggests that the system may be failing to embody national standards and international best practice. Indeed, whilst the seclusion rate in NSW comes very close to the national average, comparison with the very low rate of seclusion in other areas of Australia, such as the ACT, suggests that much more could be done to reduce the occurrence of seclusion and restraint incidents

There are many examples of international success in reducing seclusion and restraint rates and in some cases elimination of the practise without contraindications for patient or staff welfare. In fact, LeBel and Goldstein reported that reduction in seclusion and restraint results in an overall improvement in outcomes (particularly in adolescent outcomes), decreased staff-related costs (e.g., sick time, workers' compensation, and turnover), and a decline in injuries to patients⁴.

Changes to legislation alone have been shown to be ineffective⁵, rather real improvements require a combination of instruments such as:

- Policy and regulation changes, including risk management and restriction of high risk restraint procedures⁶
- State level support⁷

² UN General Assembly, 1991. *Principles for the protection of persons with mental illness and the improvement of mental health care*, 17 December 1991, A/RES/46/119.

³Hickie, I. 2009. *Ending Seclusion and Restraint in Australian Mental Health Services*. Online at https://nmhccf.org.au/sites/default/files/docs/seclusion_restraint.pdf. Accessed on 17/7/2017.

⁴ LeBel J, Goldstein R: 2005. The economic cost of using restraint and the value added by restraint reduction or elimination. *Psychiatr Serv* 56:1109–14.

⁵ Keski-Valkama A, Sailas E, Eronen M, et al. 2007. A 15-year national follow-up: legislation is not enough to reduce the use of seclusion and restraint. *Soc Psychiatry Psychiatr Epidemiol* 42:747–52

⁶ Smith GM, Davis RH, Bixler EO, Lin HM, Altenor A, Altenor RJ, Hardentstine BD, Kopchick GA, Curie CG. 2005. Pennsylvania state hospital system's seclusion and restraint reduction program. Commentary. *Psychiatric services*, 56(9), pp.1139-1140.

⁷ Gaskin CJ, Elsom SJ, Happell B. 2007. Interventions for reducing the use of seclusion in psychiatric facilities: review of the literature. *Br J Psychiatry* 191:298–303.

- Leadership and changes to organisational culture^{7,8,9}
- Staffing changes⁶
- Training and education^{6, 7,10}
- Patient, family and advocate involvement^{11,12,13}
- Better use of data to monitor seclusion and restraint episodes^{6,7}
- Review of procedures including debriefing
- Improvements in clinical care aligned with recovery oriented practice⁷
- Changes to medication policy⁶
- Psychiatric emergency response teams⁶

Legislation and Policy

While the NSW Mental Health Act 2007 does not definitively refer to the practise of seclusion or restraint, there are provisions that would cover both practises. For example, s68 (f) states that:

“any restriction on the liberty of patients and other people with a mental illness or mental disorder and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances.”

The use of seclusion and restraint to control a person who does not pose an imminent risk of harm can result in serious sanctions through the legal system. The *Mental Health Act 2007* (s69) outlines penalty units attached to the maltreatment of patients. Arguably, seclusion and restraint of people in NSW mental health facilities where alternative methods exist could be seen as an abuse of rights and attract financial penalty and/or imprisonment:

“An authorised medical officer, or any other person employed at a mental health facility, must not wilfully strike, wound, ill-treat or neglect a patient or person detained at the facility under this or any other Act. Maximum penalty: 50 penalty units or imprisonment for 6 months, or both.”

Seclusion and restraint policy directives in NSW are set out in the framework *Aggression, Seclusion & Restraint in Mental Health Facilities in NSW*¹⁴. This directive states that:

“It is the position of NSW Health that clinical and non-clinical staff working in mental health facilities in NSW will undertake all possible measures to prevent and minimise disturbed or aggressive behaviour and reduce the use of restrictive practices such as seclusion and restraint.”

⁸ American Psychiatric Nurses Association, 2001. American Psychiatric Nurses Association position statement on the use of seclusion and restraint. *Journal of the American Psychiatric Nurses Association*, 7(4), pp.130-133. Online at <http://www.psych.org/Departments/QIPS/Downloads/LearningfromEachOther.aspx>. Accessed on 17/7/2017.

⁹ Donat DC.1998. Impact of a mandatory behavioral consultation on seclusion/restraint utilization in a psychiatric hospital. *J Behav Ther Exp Psychiatry* 29:13–19.

¹⁰ Hellerstein DJ, Staub AB, Lequesne E. 2007. Decreasing the use of restraint and seclusion among psychiatric inpatients. *J Psychiatr Pract* 13:308–17

¹¹ Bloom SL, Bennington-Davis M, Farragher B, McCorkle D, Nice-Martini K, and Wellbank K., 2003. Multiple opportunities for creating sanctuary. *Psychiatric Quarterly*, 74(2), pp.173-190.

¹² Borckardt JJ, Grubaugh AL, Pelic CG, Danielson CK, Hardesty SJ, Frueh BC. 2007. Enhancing patient safety in psychiatric settings. *Journal of Psychiatric Practice*, 13(6), pp.355-361.

¹³ Greene RW, Blon JS, Martin A, 2006. *Use of collaborative problem solving to reduce seclusion and restraint in child and adolescent inpatient units. Psychiatr Serv* 57:610–12.

¹⁴ NSW Health. 2012. Online at http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_035.pdf. Accessed on 17/7/2017.

NSW Health itself acknowledges that this practise is unnecessary and that others have achieved safe alternatives to restraint and seclusion which should be a priority¹⁴:

“While seclusion and restraint are used in some mental health facilities to manage disturbed behaviour, others have found that these strategies can be safely avoided.”

The Directive sets out a detailed ethical and legal framework for the use of seclusion and restraint. Whilst this framework is generally laudable, empirical evidence and feedback from the mental health sector suggests that the policy may not be functioning as it should be. There is a gap between the policy, law and practise of seclusion, restraint, observation and culture determining outcomes for people in the mental health system. It appears that policies for oversight and review are not being adequately followed.

Data and Reporting

One Door supports strengthening the independent powers of the Mental Health Commission of NSW to gain access to all incident and mental health reporting data in NSW and that they should be mandated to report publicly on the use of restraint and seclusion.

Under the *Mental Health Commission Act 2012 No 13*, such a function could be envisioned for the NSW Mental Health Commission. *The Act* establishes:

“the Mental Health Commission of New South Wales for the purpose of monitoring, reviewing and improving the mental health system and the mental health and well-being of the people of New South Wales.” (Part 1, section 3).

Under the Act, the NSW Mental Health Commission is mandated with the task to (Part 3, section 12(c)):

“review and evaluate, and report and advise on, mental health services and other services and programs provided to people who have a mental illness, and other issues affecting people who have a mental illness”

Many of the issues outlined in this paper could be addressed were there more regular, independent, transparent and public reporting of both seclusion and restraint by the NSW Mental Health Commission. Such a precedent has been set elsewhere, such as Ireland, where the Mental Health Commission collects data on the use of seclusion and restraint, publishing their findings on nationally, regionally and in individual services on an annual basis^{15,16,17,18}.

In NSW, data and reporting on seclusion and restraint events should be improved. Central to this is an improvement in the granularity of data collected for seclusion events and the introduction of centralised collection and release of restraint data, which is currently not reported on. Data should be centrally reported directly to the Chief Psychiatrist and the Mental Health Commission of NSW.

¹⁵ Mental Health Commission, Ireland. 2012. *Seclusion and Physical Restraint Reduction Knowledge Review and Draft Strategy*. Online at http://www.mhcirl.ie/File/SecandPPR_KnowRev.pdf. Accessed on 17/7/2017

¹⁶ Mental Health Commission, Ireland. 2009. *Rules Governing the Use of Seclusion and Mechanical Means of Bodily Restraint* (Dublin: MHC).

¹⁷ Mental Health Commission, Ireland. 2011. *The Use of Seclusion, Mechanical Means of Bodily Restraint and Physical Restraint in Approved Centres: Activities Report 2009* (Dublin: MHC).

¹⁸ Mental Health Commission, Ireland. 2012. *The Use of Seclusion, Mechanical Means of Bodily Restraint and Physical Restraint in Approved Centres: Activities Report 2010* (Dublin: MHC).

The types of data collected for the calculation of seclusion and restraint rates raises a number of concerns. Currently, information available includes the rate of seclusion events per 1000 patient days. In NSW, the target for seclusion rates is less than 6.8 events per 1000 bed days in mental health units¹⁹, while in 2013-2014 there were approximately 8 seclusion events per 1000 bed days in NSW.

Who, how long for, how many times, by whom and why any individual is secluded or restrained should be centrally reported directly to the Chief Psychiatrist and the NSW Mental Health Commission. Currently none of this reporting occurs for restraint and the number (only) of seclusion events are reported to the NSW Ministry of Health. For seclusion, these may be, but are not necessarily, audited by NSW Official Visitors.

Improvements to the transparency and granularity of data are needed to identify and benchmark those facilities that are using seclusion at a higher rate than the target. For example, the current method of reporting bed days is not consistent amongst forensic services managed by correctional facilities. Similarly, the calculation of seclusion rates uses data collected from all acute bed days, including from facilities where no seclusion occurs.

Seclusion rates may also be misleading, insofar as there is no transparency over the number of times an individual may undergo seclusion events. Further, the proportion of episodes with a seclusion event may be underestimated in some facilities containing multiple acute units. This again may lead to an underestimation of seclusion rates in facilities where seclusion does occur.

The Mental Health Commission in Ireland recommends that the following data is collected and reported on based on an extensive review of literature^{18,20}:

- Total seclusion events
- Total seclusion hours
- Total number of service users secluded, including demographics
- Total number of seclusion events and total hours for each service user secluded
- The use of alternative restraints to replace seclusion e.g. medication or one to one time with staff
- The use of non-restraining methods to replace seclusion
- The number of injuries sustained by service users and staff
- The days and shifts the seclusion events occurred
- The staff member(s) involved in each seclusion event
- Analysis of both the themes and outcomes of debriefings
- Analysis of trends in use of seclusion, and of non-restraining methods

Additional auditing should report on:

- Whether the provider can justify restraint actions
- Staff awareness of best practice and the quality of de-escalation and application of the principles of positive behaviour support

¹⁹ NSW Health. 2017. *Service Agreement Key Performance Indicators and Service Measures Data Dictionary*. Online at: http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/IB2016_036.pdf. Accessed on 28/06/2017.

²⁰ O'Hagan M, Divis M and Long J, 2008. *Best practice in the reduction and elimination of seclusion and restraint; Seclusion: time for change*. (Auckland: Te Pou Te Whakaaro Nui: the National Centre of Mental Health Research, Information and Workforce Development).

- The percentage of ward/service staff who have had training in best practice restraint
- Staff de-briefings
- Evidence of a provider restrictive intervention reduction programme.

Observation

Observation policy is outlined in individual Local Health District policy. For people undergoing a seclusion event, level 1 observation should be employed. This includes, for example, interventions such as the patient being in line of sight of a nurse at all times and recorded observations at 10minute intervals. However, the great weakness in this policy is the reporting and auditing process which is internal and at local level. Measures for independent audit processes should be implemented. More regular and transparent system of consumer observation by mental health staff should also be implemented.

Other Improvements Needed in NSW Health Facilities

Mental Health Readmissions

Mental health readmissions in NSW can be an important indicator of the effectiveness of the mental health system. Readmission rates reflect, among other factors, the effectiveness of mental health services. The more effective the service upon initial contact with adequate and effective follow-up, the smaller the number of readmissions. Effective service and follow-up can also be tied to patient experience of care, improved staff morale, improved patient outcomes and a reduction in the suicide rate.

In NSW, the *Service Performance Agreements Safety and Quality* target for readmission is set at less than or equal to 13%. However, in 2014-15 the 28 day readmission rate for mental health patients was 15%²¹. One Door Mental Health supports a significant reduction in both the target and the current rate of readmission through the implementation of reforms of discharge procedures following a psychiatric in-patient admission, such as the Hospital to Home program (described in the section “Suicide After Discharge”).

One Door recognises that factors contributing to readmission rates are complex and many can be difficult to control, such as the patient’s age, sex and primary diagnosis. However, the Australian National Audit Office (ANAO) identified that improvements can be made in order to reduce readmission rates, including good transitions to out-of-hospital care and good information sharing which ensures better continuity of care for the patient.

Discharge Planning and Follow-up

Follow-up with the patient in the period after their discharge from mental health units is an important aspect of continuity of care for people with mental health conditions. There is strong evidence that successful follow-up policies can reduce costs and time associated with readmission, length of stay and suicides²².

²¹ The Australian Institute of Health and Welfare (AIHW).2015. *Key Performance Indicators for Public Mental Health Services 2014-15*. Australian Government, Canberra. Online at :

http://analytics.aihw.gov.au/Viewer/VisualAnalyticsViewer_quest.jsp?reportPath=%2FAIHW%2FReleasedPublic%2FMHSI%2FReports&reportName=MHS%20KPIs%202016&appSwitcherDisabled. Accessed on 28/6/2017.

²² Australian Government. 2011. *Key Performance Indicators for Australian Public Mental Health Services* (2nd ed). Australian Government, Canberra. Online at <file:///C:/Users/richardschweizer/Downloads/Key%20performance%20indicators%20for%20Australian%20public%20mental%20health%20services%20second%20edition%202011.pdf>. Accessed on 17/7/2017.

Typically, in NSW, follow-up rates are measured in the week following discharge and include those who have made only one contact with a Community Managed Organisation (CMO) within 7 days. The target for overnight separations from NSW acute mental health units to be followed by a recorded community contact within 7 days of discharge is currently 70%. In 2014-2015, follow-up rates within the first 7 days of discharge from an acute psychiatric inpatient admission in NSW were 63.3%²¹.

While this percentage has been improving incrementally since 2005-06, this level of follow-up is fundamentally inadequate, both in number of contacts and the period over which contact is followed and reported on. Furthermore, there is a lack of transparency regarding the quality or outcome of contact. In 2011, it was reported that of those that did receive follow-up psychiatric treatment in the community, only less than two thirds received a single session of 30 minutes²³.

Suicide After Discharge

One of the most distressing features of mental health care is the rate of attempted and successful suicide immediately following discharge from a mental health service, when consumers are most vulnerable²⁴.

Although we were not able to obtain suicide rates following discharge in NSW, studies internationally suggest the rate of suicide within 3 months of discharge could be as high as 20%²⁵. In WA, of those who died from suicide following discharge from a psychiatric unit, 15% of men and 20% of women completed suicide on the day of discharge and a third completed suicide within a month of discharge⁷.

The NSW mental health sector should aim higher than they are currently achieving. NSW should publically report this data and aim to reduce suicide and suicide attempts to nil following discharge. Hospital readmissions and suicides that occur after discharge from in-patient psychiatric care are completely preventable.

In 2015-16, One Door trialled the Hospital to Home Peer Support Program (H2H), receiving 125 referrals over 18 months. During this time there were no suicide attempts, no emergency department presentations and only one readmission following discharge.

H2H is a 6-8 week program whereby peer support recovery workers are involved in planning of discharge and continue follow-up throughout the discharge process and integration back into the community. This program works at busy Sydney and regional hospitals. Independent evaluation, stakeholder feedback and letters of support from hospital staff are all evidence that we improved clients' recovery, wellness and independence.

Discrimination in the Health System

²³ Department of Health and Ageing. 2013. *National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993 – 2011*. Commonwealth of Australia, Canberra.

²⁴ National Mental Health Performance Subcommittee. 2011. *Key performance indicators for Australian public mental health services*. (2nd ed). Canberra: NMHPSC.

²⁵ Meehan J, Kapur N, Hunt IM, Turnbull P, Robinson J, Bickley H, Parsons R, Flynn S, Burns J, Amos T, Shaw J, Appleby L. 2006. Suicide in mental health in-patients and within 3 months of discharge. National clinical survey. *Br J Psychiatry*;188:129-34.

As in many parts of Australian society, people living with a mental illness experience discrimination within the mental health system. Employment of peer workers within the health care system can significantly reduce discrimination experienced by mental health consumers. One Door Mental Health commends NSW for including a Key Performance Indicator aimed at increasing the peer workforce within the health care system, although a clear target for a proportion increase should be considered.

THANK-YOU

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