



ACT Mental Health Consumer Network Inc.

The Griffin Centre, Level 2, Room 11
Genge St. CIVIC
P.O.BOX 469 – CIVIC SQUARE- ACT 2608
Phone: 02 6230 5796 Fax: 02 6230 5790
Email: actmhcn@actmhcn.org.au
Website: www.actmhcn.org.au

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Ms Anna Grealy
Policy & Project Officer
Policy & Projects
HealthCARE Improvement
ACT Health
Anna.Grealy@act.gov.au

Dear Anna

Restraint of Patients Policy and SOP and the Code Black and Physical Restraint of Patients Process at the Canberra Hospital – ACT Mental Health Consumer Network comments

Thank you for the opportunity to be part of the *initial* consultation on the above Policy, SOP and Process. We have consulted our members, including through a forum specifically seeking comments on these documents, and now provide the following comments. They focus primarily on the Policy document, and in many cases the same comments flow through to the SOPs.

Policy – Restraint of Patients

The intentions of the policy appear to be to minimise the use of any form of restraint, and to ensure restraint is used only as a measure of last resort where there is no other option to avoid greater harm than that caused by the use of restraint. We support this intent. The Network considers that this purpose could be better realised if additional measures were included to improve the range of options open to staff to reduce the perceived need for restraint.

A policy is only as good as its implementation. Network members have raised concerns that there is a lack of mechanisms to provide accountability and transparency around

restraining patients. Too much of the reporting relies on evaluation of whether action was justified by the individuals taking the action.

The Policy recognises that the use of restraint measures may cause physical damage and/or emotional harm. In referring to emotional harm, the Policy should specifically refer to ‘trauma’ as a possible result of the use of restraint. It should also state that care of a person who has been restrained should be trauma informed.

Scope

The Policy states that it and the SOPs relate to ‘environments where patients are under the care of Health Directorate’. It says it does not apply to restraint of non-patients. The status of a person who is seeking treatment should be clarified – we believe that the Policy and SOPs should also apply to a person seeking treatment as if they were a patient, at least in the Emergency Department setting.

The Policy states that it and the SOPs “do not cover ‘seclusion’ as defined by the *Mental Health (Treatment and Care) Act 1994*”. That Act (‘the Mental Health Act’) does not define ‘seclusion’, so this statement is confusing. It also treats ‘restraint’ and ‘seclusion’ as separate things – so it is not clear whether this Policy is intended to apply to ‘restraint’ that is also regulated by the Mental Health Act.

The Mental Health Act regulates the circumstances in which a person who is involuntarily apprehended or detained under the Mental Health Act may be restrained or secluded, and some practices and record keeping that must accompany either restraint or seclusion. If the intention is that the overarching Policy and SOPs do not apply where restraint or seclusion is governed or regulated by the Mental Health Act, it should state that more directly.

The interaction with local SOPs, such as the SOP that applies to involuntary mental health consumers, is also not clear. As we understand it:

- the ACT Health Policy and SOPs apply to voluntary patients in the Adult Mental Health Unit, as restraint or seclusion is only regulated by the Mental Health Act for involuntary patients; but
- the ACT Health Policy and SOPs do not apply to involuntary patients in the Adult Mental Health Unit, as the Mental Health Act regulates restraint or seclusion of involuntary patients.

This is not clear from the statement in the Policy. There should be a clear statement that a mental health consumer who is subject to Emergency Action, Emergency Detention or a Psychiatric Treatment Order may only be restrained if this is authorised by the Mental Health Act and in accordance with the local SOP that applies to restraint of involuntary mental health patients. It should also be made clear that the overarching

Policy and SOPs do apply to restraint of mental health consumers who are voluntary patients in the hospital or in community settings.

In addition, the local SOP applying to mental health consumers who are involuntary patients is not publicly available. We strongly suggest that all relevant local Policies and SOPs should be available on the ACT Health website together with the overarching documents.

Evaluation

It is of great concern to our members that all of the reporting mechanisms rely on staff judgment of the appropriateness of their actions, or staff evaluation of whether an outcome is adverse. It is critical to appropriate governance and transparency that consumers and carers are able to require a record to be made.

In our view, the documentation and recording requirements are insufficient to enable the use of restraint to be adequately tracked or monitored. In particular, we are concerned that much of the information is recorded only in the individual's file. Some members have reported obtaining access to their health records and finding no record of incidents in which they were restrained, or a record which they consider misleading.

All uses of restraint should be centrally recorded, and the data made publicly available. These records should include the type and duration of restraint, and whether or not there was consent for its use. In addition, it is inadequate to rely on staff reporting of adverse outcomes. Staff have informed consumers on a number of occasions, unofficially, that they under-report a range of incidents to Riskman. We suggest that patients and carers or family members should also be able to trigger a report of adverse outcomes on Riskman. For this to be effective, after every incident of restraint being used there should be a requirement for staff to ask the patient, and carers/family members, whether they consider there are any adverse outcomes; and their view of the outcomes should be recorded in Riskman if the patient or their carer/family members consider the outcomes to be adverse, and in the individual's file in all cases.

It is also imperative that ACT Health take action to ensure that staff are reporting all incidents that should be reported on Riskman.

Legislation

We consider that the Policy does not adequately inform staff about their legal situation. The Policy is clear that restraint is a measure of last resort, but this statement is inadequate. The Policy should include a paragraph that clearly states that restraining a person mechanically, physically, environmentally or chemically may be a criminal assault under the Crimes Act. The Policy should state that a person does not have authority to restrain someone simply because they are a member of a treating team or a member of staff, and the person a patient. It should be clear that there must be legal

authority for the action, and set out the circumstances and procedures that provide that authority.

The Policy should also include a statement about what ACT Health will do if a member of staff is considered to have restrained a patient without lawful excuse. In our view, any allegation that a person has been restrained without lawful excuse should be subject to internal review and, if there remains any question about whether the action was authorised, referred to police for investigation as a potential assault.

The Policy lists 'Related Legislation and Policies'. The Crimes Act should be added to this list.

Definitions

We consider that the definition of 'restraint' should include 'threats of restraint'. Mental health consumers have reported numerous instances where they have been threatened with restraint because their behavior is considered challenging or non-compliant. Restraint must never be used as a threat in an attempt to control behaviour seen as undesirable by staff.

Threats of restraint can themselves be traumatising and are a form of control that should be treated with the same degree of seriousness as other incidents of restraint. Other jurisdictions have recognised that threats should be treated as a form of restraint – e.g. the *Mental Capacity Act 2005* (UK) defines restraint as *the use or threat of force where an incapacitated person resists, and any restriction of liberty or movement whether or not the person resists* (s.6(4)).

The ACT would benefit from creating a specific category of restraint that covers any threat of the use of other forms of restraint. We suggest calling it something like "restraint by threat" and define it as "the direct or implied threat to use physical, chemical, environmental or mechanical restraint against a patient". The same requirements with regard to the use of restraint should exist for restraint by threat (including with regard to authorisation, documentation, review and reporting).

Environmental restraint – it appears to us that 'seclusion' as regulated by the Mental Health Act is within this definition. It is not clear whether there is intended to be a difference. It should be made clear in this Policy that an involuntary patient cannot be subjected to environmental restraint except in accordance with the Mental Health Act.

Sedation – the line between 'treatment' and 'restraint' is very blurred in this area. In our view, all use of treatment that is by its nature restraining, such as heavy or long term sedation, should be treated as restraint and reported as such.

Mental health consumers have repeatedly reported the use of medication or threats of medication as punishment for 'misbehaviour' in ACT mental health facilities. Whether or not this is the intention, the perception of medication as punishment can undermine any benefit to be gained as well as the relationships between the consumer and staff. The

Policy should make clear that no patient should ever be threatened with sedation as a means of controlling their behavior.

In particular, with the prohibition of smoking for mental health consumers in place, and the new prohibition to apply across The Canberra Hospital, the Policy and SOP should make very clear to staff that it is never acceptable to threaten the use of restraint, including seclusion, isolation or sedation, to manage the behavior of an addict denied a cigarette.

Standard Operating Procedure: Restraint of Patients

In addition to changes that would flow from the comments on the Policy document, we have some specific suggestions for changes to the SOP.

1. Emergency Situations

The first paragraph under this heading refers to ‘a life-threatening emergency’ and the second paragraph refers to ‘an emergency’. It is not clear whether these are two different situations and, if so, what non-life-threatening emergencies are intended to be covered.

2. Assessment of Patient

We support the intention of seeking to address underlying issues, rather than focusing on the potentially harmful behavior. There should be a requirement, in conducting the assessment, to involve the patient, and any carer, in this assessment. There should also be a requirement to document the patient and/or carer’s input to the assessment in the person’s clinical record.

We also suggest that two additional factors to be considered should be added to the existing list:

- History of trauma; and
- Nicotine withdrawal.

3. Alternatives to Restraint

An additional measure that should be included in the list of alternatives to be considered is a family member/carer/supporter of the person to stay with them, to provide support. We are aware of instances where family members or friends have not been permitted to stay with individuals, and those individuals believe that the presence of the family member or friend would have assisted in avoiding or curbing behavior that led to incidents of restraint being used.

5. *Authorisation*

In addition to the matters set out as needing to be documented in the clinical record, the Medical Officer should also document the harm sought to be prevented by the use of restraint.

There are some circumstances where it is predictable that restraint *may* be required. This should be discussed with the patient at the earliest opportunity, and their preferences and wishes recorded and adhered to.

9. *Care of the patient during restraint*

The list of checks to be performed at least every hour should include “Monitor for trauma or other psychological distress”.

In addition, we believe that a patient or their carer/family member should have the right to record the use of any form of restraint, if they so wish.

12. *Post Restraint*

Every patient should have the right to contribute to the assessment of the use of restraint, and its outcomes. The patient’s view must be recorded in every instance. As discussed above, where the patient considers there to be adverse outcomes, this must be recorded in Riskman as well as the patient’s record.

Evaluation

The results of the Riskman audit carried out every six months should be made public.

The Network thanks you again for the opportunity to provide comments. We understand that there will be further consultation on these documents, as this is an initial consultation, and look forward to further engaging with ACT Health on these important issues.

Yours sincerely



Dalane Drexler
Executive Officer
ACT Mental Health Consumer Network