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Submission:

Canberra Health Services– Emergency Department Model of Service June 2023

Submitted by email to:

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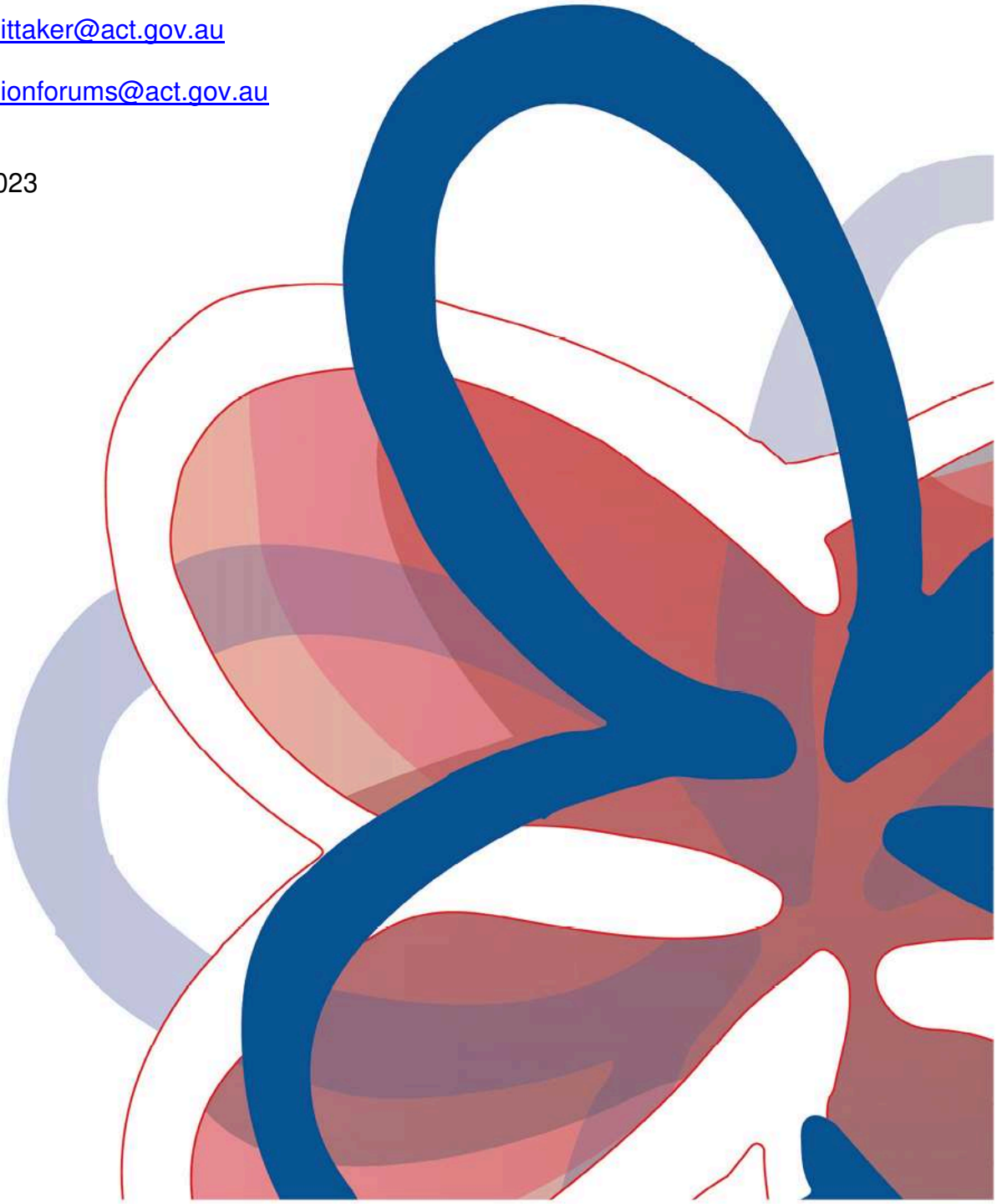

Submission: Canberra Health Services Emergency Department Model of Service

The Network is a consumer-led peak organisation representing the interests of mental health consumers in the ACT in policy and decision-making forums. The Network is committed to social justice and the inclusion of people with experience of mental illness. Run by consumers for consumers, our aim is to advocate for services and supports for mental health consumers which better enable them to live fuller, healthier and more valued lives in the community.

A consumer hybrid discussion group was held, and additional feedback was sought via email in relation to the CHS – Emergency Department Model of Service document. Written and verbal feedback was received from several consumers. This submission incorporates both the written and verbal feedback received.

Acknowledgement of Country

We wish to acknowledge the traditional owners and custodians of the land upon which we sit. We pay our respects to their Elders past, present and emerging, and extend this respect to other Indigenous Australians who may be reading this submission. We recognise the ongoing contributions of all Indigenous peoples to ACT society and Australia more broadly.

Acknowledgement of people with lived experience

We also acknowledge people with lived and living experience of mental illness as consumers and their important lived experience expertise and ongoing contributions to the mental health sector."

General comments

The Network welcomes this opportunity to contribute to the Canberra Health Services (CHS) Model of Service (MoS) for the Emergency Department (ED).

Consumers do not endorse seclusion

Consumers have clearly stated that their provision of comments and recommendations regarding this Model of Service in no way endorses or legitimises the use of seclusion in Emergency Departments. Consumers referenced research around the trauma caused by seclusion and its limited efficacy as a therapeutic technique to keep people safe.

Consumers draw your attention to Recommendation 54 in the *Final Report of the Royal Commission into Victoria's Mental Health System*[1]. This recommendation identifies the goal of erasing seclusion and restraint in mental health and wellbeing service delivery within the next 10 years.

While consumers' first recommendation is to eliminate seclusion as an intervention, consumers have elected to provide recommendations to this Procedure recognising that it is included in the *Mental Health Act 2015* (ACT) (the Act). In addition, they acknowledge that the elimination of seclusion practices would require changes to the Act which is a necessary but longer-term project.

Nominated Person, Advance Consent Direction and Advance Agreement

The wording and provisions for decision-making in the Act should be included in the MoS where appropriate. The Act provides mental health consumers with the ability to complete forms to put in place the following supports for when they become unwell:

- Advance Agreement;
- Advance Consent Direction; and
- Nominated Person.

It is important that these instruments are noted correctly in the MoS in all relevant places. The MoS should be clear in all relevant places that the decisions a consumer has made in their Advance Agreement, Advance Agreement and/or Nominated Person forms constitute consent for periods when they have reduced decision-making capacity. These are important instruments which support treating teams to treat a person when they have reduced decision-making capacity.

A consumer's Nominated Person is a trusted person they have identified to support their decision-making should they have reduced capacity or need assistance regarding their mental health treatment. The Advance Agreement and Advance Consent Direction provide essential information about a consumer's treatment, care and other details of importance. All three of these instruments, if in place, are noted on a consumer's Digital Health Record (DHR) in case of future need.

[1] Royal Commission into Victoria's Mental Health System: Final Report, Recommendations, Plain language Version (https://finalreport.rcvmhs.vic.gov.au/wp-content/uploads/2021/02/RCVMHS_FinalReport_PlainLanguage_Recommendations.pdf)

A consumer's Nominated Person is the appropriate person to contact, rather than (or in addition to) a possible next of kin, carer, guardian, family member or friend. A consumer's Advance Agreement and Advance Consent Direction provide details about who can and cannot be contacted when a person presents for hospital care and treatment. They can also outline de-escalation techniques that work for them, reducing the need for seclusion.

Consumers noted that this reference needs to be at the beginning of the following sections: p. 8 - *4. Models of Care and Patient Journey* and when considering specific medical units such as p. 22-25 - *Behavioural Assessment Unit*.

Overarching Comments

- Consumers were disappointed to note that no Consumer Representative was included in the development of the MoS, as evident in the participants list, p. 44. To ensure the consumer voice is embedded in the development of future model of service documents, consumers recommend that the consumer voice be involved from the beginning.
- Language and terminology need to be consistent throughout the document – see recommendation 2 further in this submission.
- The use of trauma informed language and the principles outlined in the Behavioural Assessment Unit (BAU) should be used throughout the document. If a person remains in the Emergency Department for longer that the expected timeline which is usually less than 24 hours, there is limited access to personal items, meals etc. The provision of basic self-care items should be provided in all rooms.
- There is no mention of discharge plans for consumers who have been in the BAU, noting that a discharge in under 24 hours could see some consumers who attended the Emergency Department in crisis leaving with no plan to follow.
- The MoS seems to be focussed on people who speak English as a first language and who have no sensory impairments. There is little for people who are hearing impaired and/or vision impaired and people who speak English as a second language (or not at all). This is most concerning during the initial triage process which can be very traumatic and difficult for people and their support persons.
- Consumers were disappointed that the BAU, where majority of people experiencing mental health crisis are to be assessed and managed, is intrinsically linked with criminality as the BAU is where all patients being treated under Section 309 of *Crimes Act 1900* (ACT), are to be managed unless found to be clinically unsuitable.

- The structure of the document needs to be consistent. For example, some tables had 'Principles for Children' as a heading while others did not, see p. 14, *4.5 Resuscitation*, compared to p. 16, 4.6 Fast Track. Consumers are concerned that if not consistent, mistakes could be made.
- The current tables are not accessible for people who use an e--reader for sight impairment or other reasons. Consumers recommend this be fixed as it is likely to be read using such technology.
- The MoS does not include the requirement that a person's consent must be obtained if their carers, families or support persons are to be involved in their care. Consumers were greatly concerned that the reason for the admission and aspects of their ongoing care might be discussed with people they would not consent to receiving such information.
- Consumers suggested that, for ease of access, the layout of the MoS should follow the Emergency Department Model of Service Flow rather than based on 'clinical rooms'. There were several parts included in the MoS document that were not discussed in the actual MoS Flow which was confusing. They suggested that the MoS Flow could appear at the beginning of each 'Room' to indicate where in the MoS the person is.
- The performance indicators did not always identify the measurement of a positive element of care and did not measure important issues, such as including 'rates of seclusion' rather than frequency of seclusion.
- Consumers were concerned that the Mental Health Short Stay Unit (MHSSU) is not included in the document and requested further explanation.
- Consumers commented on the lack of reference to Official Visitors and Public Advocates.
- Consumers seek clarification as to what the impact of the new Northside Hospital coming on line will have on both policy, procedure and model of service documents.

Recommendations

Recommendation 1: Explain and provide evidence for claimed evidence-based framework
Consumers were not able to ascertain what evidence the new MoS was based on. Consumers recommend that if the MoS is claimed to be evidence-based, the evidence should be included somewhere in the document, even it if is an Appendix.

Recommendation 2: Inclusion of support persons and nominated persons
Consumers questioned why dot point three, page 5, had family members and carers in brackets, and recommend it should be part of the main text as well as support

person and nominated person. In addition, consumers questioned the use of the term 'family members' and 'significant others' and recommend the inclusion of **nominated person** and **support person** in every instance, such as, but not limited to, the following sections: pp. 11-12 in *Waiting Rooms and Support*; p. 13 in *Clinical Initiatives Nurse*, p. 23 in *Behavioural Assessment Unit*, and p. 28 in 5.1 *Children's Emergency Medicine Unit*.

Recommendation 3: Inclusion of consent
Consumers recommend including ***with consent*** in the document when involving anyone else in a person's care. Examples of areas in the document where consent should be included are pp. 4, 11 and 23.

Recommendation 4: Include Cultural and Linguistic Diversity
Consumers recommend the inclusion of Culturally and Linguistically Diverse groups in the 4th dot point, p. 5, when discussing acknowledging different groups.

Recommendation 5: All patients should be cared for in clinically appropriate areas
Consumers recommend that the statement under *4.7 Acute*, *Older persons in ED will be cared for in clinically appropriate areas in an environment that promotes low stimulus* be changed to: ***All persons in ED will be cared for in clinically appropriate areas. An environment that promotes low stimulus will be available for all suitable patients including, but not limited to, patients with mental ill health and/or mental disorder, older persons etc***. Consumers noted that not all older persons may want to be in a room that promotes low stimulus.

Recommendation 6: Ensure clarity when referring to legislation
Consumers would like to see the document formally identify relevant parts of legislation when specifically included in the MoS. For example, p. 23 refers to Section 309 (s309) and p. 24 refers to Section 309, with neither specifying which document it is referring to. These examples should be written as e.g. 'Section 309 of the *Crimes Act 1900* (ACT)'. In addition, consumers recommend using hyperlinks to specific Sections in the Acts so when read electronically the reader can go straight to the reference.

Recommendation 7: Rewrite management plan statement in relation to BAU
Consumers advised that the following sentence on p. 23 needs to be rewritten as it was unclear and confusing and doesn't appear relevant to this document: 'People with frequent presentations whose management plan indicates BAU admission is not advisable'.

In addition, consumers were concerned that the use of the term 'frequent presentations' is pejorative and goes against the concept of patient centred care. The MoS is also not clear what frequent presentations refers to.

Recommendation 8: Important edits to the Principles section, BAU
Consumers noticed that this section seemed to have been written in more haste and with less care than the other sections in terms of accuracy and editorial requirements.

Consumers recommend the rewriting of the Principles section on pp. 22-25, including the following changes:

1. Change the words 'his/her' to ***their***. Consumers recommend ALL CHS documents be searched for such pronouns and that they be changed to ensure gender inclusivity.
2. Remove the term 'significant others' and include ***Nominated Person*** as it is very likely people with mental illness will be assessed in this unit.
3. Change the last dot point on p. 23 as consumers advise that, while all these issues are important and need to be addressed, they do not think it is realistic to think that a person's "…housing, social contacts, diet, exercise and work…" can be resolved when someone is at the point of crisis, in the Behavioural Assessment Unit, with an expected timeframe of less than 24 hours.
4. The list of dot points under the subheading *Trauma Informed Care* are not only appropriate for persons living with mental health conditions. Trauma informed care is the acknowledgement that anyone may have experienced trauma and this MoS should make this clear at the beginning.
5. Identify the relevant sections of Legislation when discussed under performance indicators.

Recommendation 9: Removal of contradictory words around least restrictive practices in the Behavioural Assessment Unit
Consumers expressed concern around the language regarding least restrictive practices and the Performance Indicators. Page 24 identifies *Least Restrictive Principles of Care* for the BAU as providing safe physical, psychological and relational environment in the spirit of least restrictive practice. However, it then includes 'Rates of Forcible giving of medication' and 'Rates of Seclusion' under the heading *Performance Indicators,* which do not envisage least restrictive care.

Recommendation 10: Edit section 4.10 Seclusion

In line with the statement made earlier regarding seclusion, consumers had several concerns with *Section 4.10, Seclusion*, p. 26, and recommend the following areas for change:

1. Inclusion of statement to check if a consumer has Advance Consent Direction, Advance Agreement and/or Nominated Person documentation in their DHR. The information included in these forms can assist with identifying the right person to contact to alleviate concerns, for example, who is to pick up children from school and feed the pets, as well as therapeutic treatments that can assist with de--escalation.
2. Seclusion, and who needs to be advised of seclusion, is a process that is governed by the Act as well as several policies and procedures. There was concern expressed regarding how little information is provided in the MoS regarding this traumatic process. Consumers recommend that the processes specified in the Act (i.e. *s83 - Statement of action taken*; *s88 - Treatment during detention*; and any additional sections that may be relevant with respect to Orders, as applicable to individual circumstances) need to be included in this MoS to protect both consumers and clinical staff.
3. Consumers were concerned with the 'Benefits' of Section 4.10, p. 26 identified as 'Person-centred environment' and 'Improved patient outcomes'. Consumers disagree, stating that no Seclusion Room is person-centred and that a person's outcomes are rarely improved by being secluded.
4. Performance Indicators should include duration of seclusion, not just frequency, and should be categorised in least restrictive measure as specified in the Act, for example **lower** rates of seclusion.

Recommendation 11: Remove performance indicator 'rates of forcible giving of medication'

The MoS does not include the use of restraint in any of the Model of Care descriptions and principles, with which consumers are in general agreement. However, the rate of forcible giving of medication (also known as chemical restraint), is included as a performance indicator at p. 24 – *Behavioural Assessment Unit*, p. 25 – *Safe Assessment Room*, and p. 26 – *Seclusion*.

Consumers recommend that these performance indicators be removed from the MoS. If they are included, further extensive work needs to be done to outline how people subject to restraints are to be managed in line with the Act.

Recommendation 12: Move section 5 to the beginning of the document
Consumers suggested that *Section 5 Innovation* be moved to the beginning of the document as it identifies the services available in the new Emergency Department, and defines what the different units are, such as the BAU. At the very least, consumers recommend that the reader is provided a link to the definitions of the different units.

Consumers also recommend the following changes:

1. 'behavioural vulnerability', p.28, *5.5 Behavioural Assessment Unit (BAU)*, is not a term consumers were familiar with and changing it to something more recognisable is recommended.
2. 5.*8 Low Stimulation Room*
    a. this section mentions children and adolescents having access to de-escalation and self-management techniques to reduce restrictive practices. This is the first time these two important issues have been raised in the MoS. Consumers are concerned that children and adolescents are being subjected to restrictive practices, and no information has been provided regarding how this can be done safely.
    b. the provision of a low stimulation room can assist a range of people, not just children and adolescents, in de-escalation and self-management, reducing restrictive practices for all. If this room is for children and adolescents only, another should be built/included for adults.

Recommendation 13: Principles of care be across all units and rooms
Consumers were concerned that, as the principles of care are associated with particular units/rooms/places of care, if the consumer is not directed to the right place, or there is no space left in the right place, the core principles of treatment for consumers with mental illness and/or mental disorder won't be available. For instance, if a consumer with mental illness and/or mental disorder is not triaged to the BAU, does that consumer still have access to the 'specialised care for those patients presenting to the ED with behavioural vulnerability' and provided with 'care in a safe therapeutic setting with close observation and timely access to specialist services'?

Recommendation 14: Inclusion of additional members of the workforce
Consumers recommend the following members of the workforce be included in *Table 1: Workforce Categories,* p. 33-34:

1. students should be included in all sections;
2. specific identification of specialist staff that are discussed in the document, including but not limited to: p. 14 - specialist children resuscitation staff, p. 24 - appropriately skilled staff in behavioural disturbance, p. 34 - staff skilled in the management of Alcohol and Drug conditions;
3. Allied Health should be all in one box, consumers were not sure why there was a box for Allied Health and a box for Allied Health continued, p. 34;
4. Support workers including Peer Workers, Aboriginal Liaison Officers should be included; and
5. Psychologists should be included.

Recommendation 15: Inclusion of Charter of Rights for People with Mental Illness and/or Mental Disorder
Consumers recommend references to the *Charter of Rights for People with Mental Illness and/or Mental Disorder* in appropriate places throughout the MoS.

Recommendation 16: Inclusion of Mental Health Act 2015 (ACT)
Consumers noted with concern that the *References List* at pp. 41-2 does not include the Act under *11.4 Legislation* and recommended this needed to be accurately referenced.

Additional information
Editorial changes

- Editorial changes have been made directly on the Word version of the MoS, Attachment A to this submission.

Conclusion
Consumers welcomed the opportunity to comment on the MoS for the new Emergency Department as part of the Canberra Hospital Expansion Project. The lack of consumer consultation during the drafting of this document is disappointing, and consumers requested that they be invited to participate in any future drafting of MoS, Procedures, Policies etc at the earliest possible point to reduce problems that can arise through late invitation.