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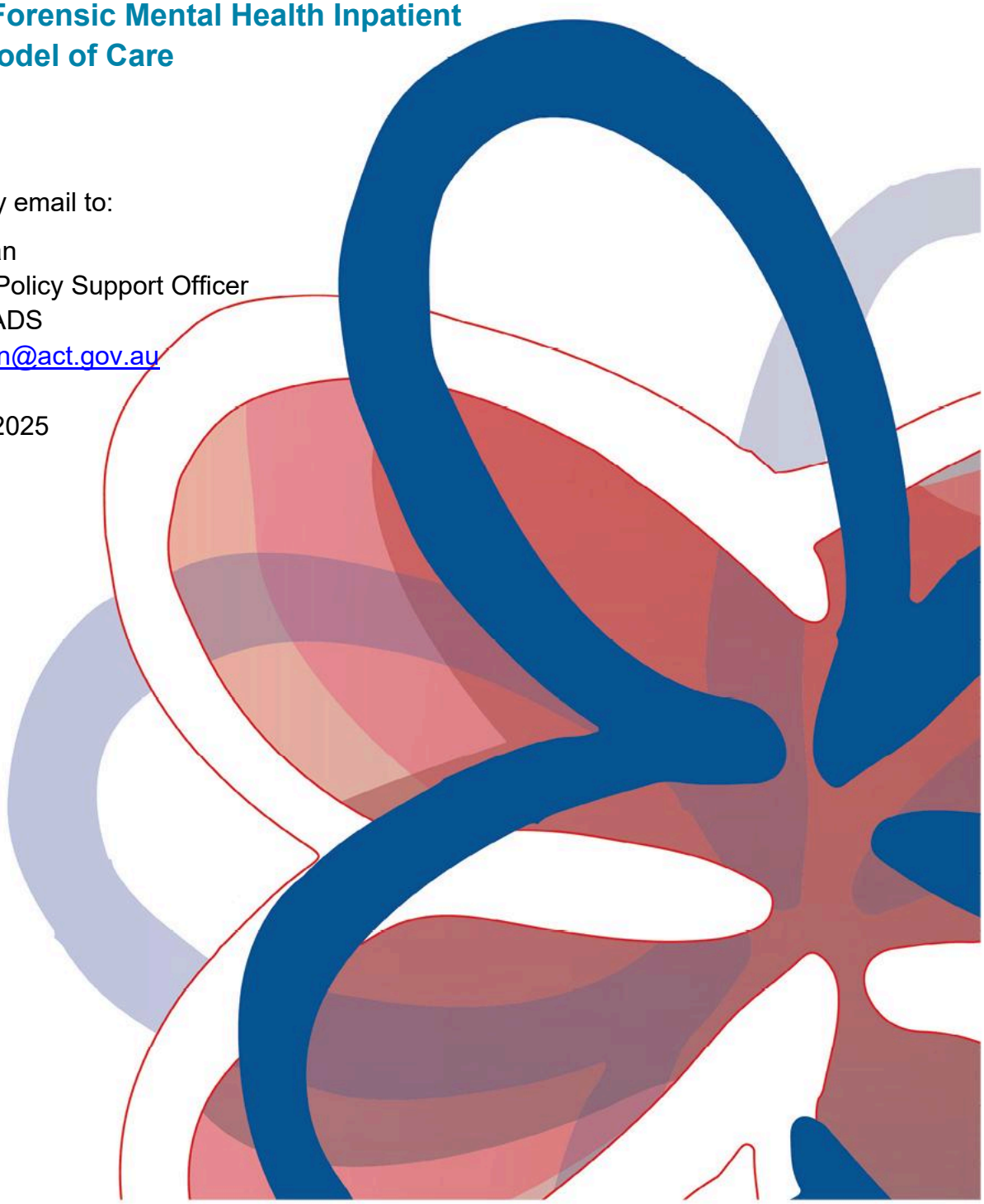
# Submission: Response to Canberra Health Services Forensic Mental Health Inpatient Service Model of Care



Submitted by email to:

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**Submission: Response to Canberra Health Services Forensic Mental Health Inpatient Service Model of Care**

This submission has been prepared by the ACT Mental Health Consumer Network (the Network) in response to the invitation from Canberra Health Services (CHS) Mental Health Justice Health and Alcohol and Drugs Services (MHJHADS).

**Acknowledgment of Country**

We wish to acknowledge the Ngunnawal people as traditional custodians of the land upon which we sit and recognise any other people or families with connection to the lands of the ACT and region. We wish to acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region. We would also like to acknowledge and welcome other Aboriginal and Torres Strait Islander people may be reading this submission, and we recognise the ongoing contributions of all Indigenous peoples to ACT society and Australia more broadly.

**Recognition of lived experience**

We wish to recognise people with mental health illness whose resilience and work contributes to creating a better mental health system for the Australian Capital Territory (ACT) and a more compassionate society for all.

**The ACT Mental Health Consumer Network**

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 Policy Forum was held for the CHS Forensic Mental Health Inpatient Service Model of Care version 2 (the MoC). During the Policy Forum, consumers discussed the CHS Forensic Mental Health Inpatient Services Model of Care version 1.3 (2024). To ensure clarity of the discussion about the MoC that is under review, where it is necessary to refer to this prior version, it will be referred to as the FMoC v1.3. Verbal and written feedback received from consumers is incorporated in this submission.

**General comments.**

The Network welcomes this opportunity to contribute to the MoC. Consumers appreciated the need for the MoC to be updated due to the closure of Gawanggal.

Consumers highlighted several issues in the MoC relating to:

- Consumer rights;
- Restrictive intervention practices;
- Framing of recovery in forensic settings; and
- Training requirements.

Each of these will be addressed in turn with recommendations summarised in the following section. Importantly, the formatting of the MoC has resulted in the sections of the document being misnumbered from Section 8 Creating a Safe Environment (p. 16) onwards. The Section for Safety and Security should be Section 9; however, it is also designated as Section 8. This error is reflected in both the contents page and body of the MoC. As such, where it is necessary to refer to misnumbered sections in this submission, we have tried to avoid confusion by instead referring to the name of the section rather than its number.

### *Consumer rights in forensic inpatient settings*

Consumers observed that the MoC discusses consumer rights in the context of staff training, legislative obligations, and information. Additionally, the MoC states that consumers have the "same rights to access and quality health care as the general population" (p. 6). In principle, consumers approved of this inclusion, but they also felt that this statement does not reflect what actually happens in forensic inpatient services. Consumers expressed concerns about how the MoC will uphold consumers rights in practice and they drew attention to three issues that are important for the MoC to address:

- Risk management & removal of privileges;
- Medication advice and choice; and
- Withdrawal and addiction management.

Consumers acknowledged that risk management is an important feature of mental health care provision in forensic inpatient settings and that Dhulwa is a medium security treatment facility. However, consumers were concerned that the MoC does not properly acknowledge the importance of ensuring that the application of risk management procedures are balanced with consumer rights and recovery goals. They stressed that the removal of privileges directly impacts consumer rights and can negatively affect recovery, particularly if privileges are rescinded for extended periods. Consumers also reported that the power to remove privileges can be used punitively rather than for safety or therapeutic reasons. In view of this, consumers recommended strengthening Section 8 (pp. 16-18) to add statements to:

- Emphasise the importance of upholding consumer rights in risk management decision making; and

- Ensure decisions to restrict “leave and access to activities and property” (p. 17) are not to be employed punitively and should only be taken in accordance with risk and safety considerations.

Suggestions for how these statements can be worded and included in the MoC are provided in the Recommendations section.

Consumers stated that agency and consent concerning medication and therapeutic options in a forensic mental health service setting was a difficult issue in that consumer concerns and preferences may be dismissed or overruled. Consumers acknowledged that the circumstances of a consumer’s admission will affect the extent of their decision-making rights in forensic inpatient settings. They nonetheless stressed the importance of supporting consumer agency and upholding their rights regarding medication and therapeutic options. For example, consumers discussed the potential for onerous side effects arising from long-acting injections (LAI) and emphasised the importance of trialling a short acting version prior to committing to a LAI. Similarly, some consumers reported that the right to have a second psychiatric opinion on medication or other therapeutic interventions was not always fulfilled, even when requested. Consumers therefore recommended the inclusion of statements in Section 7 that affirm CHS’s commitment to upholding consumer rights regarding medication management and requesting a second opinion. Suggestions for the wording of these statements are included in the Recommendations section.

Consumers highlighted the importance of adequate withdrawal and addiction support and management. They discussed the impact of inadequate withdrawal and addiction planning and related how mismanagement of nicotine supports or pain medications had exacerbated underlying conditions and impeded their recovery. Consumers noted that ensuring that addiction and withdrawal supports are adequately tailored to the needs of consumers is a component of upholding a consumer’s right to quality health care as well as supporting their recovery journey. They therefore recommended the inclusion of a statement in Section 7 that affirms CHS’s commitment to ensuring that care planning is adequately responsive to a consumer’s needs, particularly for the management of withdrawal and addiction. An example for the wording of this statement is included in the Recommendations section.

### *Restrictive intervention practices*

Consumers observed that the MoC does not address the use of restrictive intervention practices (seclusion, restraint and forcible giving of medication), despite it being a part of the service’s monitoring and evaluation. For instance, the

Monitoring and Evaluation section specifies the "percentage of incidents of restrictive practice where a post-incident consumer debrief was offered" (p. 29) as a key performance indicator. Consumers were alarmed by this omission from the MoC due to the well-documented risks and harms of restrictive intervention practices.[1] Although consumers acknowledged the inclusion of Safewards in the Safety and Security section (p. 20), they stressed that it is still necessary to articulate the role of restrictive intervention practices within the MoC.

Consumers therefore recommended including a subsection in the MoC that addresses the use of restrictive intervention practices. They further recommended that the section should:

- Explicitly acknowledge the nationally recognised principle[2] of reducing and eliminating the use of restrictive practices where possible as a priority for risk management and harm minimisation;
- State that the restrictive intervention practices will only be employed as a measure of last resort where first resort options have been exhausted or are not feasible for the situation at hand;
- Indicate what approaches are to be considered and employed as first-resort options prior to escalating to restrictive intervention practices in accordance with the *Challenging Behaviour Guidelines for Health Services* (2024)[3]; and
- Review and update the Monitoring and Evaluation section (pp. 27-28) to ensure that all restrictive intervention practice notification and reporting obligations are included in the key performance indicators table.

As appropriate, example statements for addressing these concerns in the MoC are provided in the Recommendations section.

### *Framing of recovery in forensic settings*

Consumers expressed concern about the framing of recovery in forensic inpatient services. They highlighted the following statement from Section 6.1 p. 10:

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[1] Australian College of Mental Health Nurses (ACMHN). (2019). *Safe in care, safe at work (SICSAW): ensuring safety in care and safety for staff in Australian mental health services*. ACMHN, Canberra, ACT, p. 8.

[2] National Mental Health Commission. (23 September 2023). *Reducing Restrictive Practices*. Australian Government. Accessed online: https://www.mentalhealthcommission.gov.au/lived-experience/contributing-lives%2C-thriving-communities/reducing-restrictive-practices; and, Australian Health Ministers' Advisory Council. (15 December 2016). *National principles to support the goal of eliminating mechanical and physical restraint in mental health services*. Safety and Quality Partnership Standing Committee. Accessed online: https://www.mentalhealthcommission.gov.au/publications/national-principles-support-goal-eliminating-mechanical-and-physical-restraint-mental-health-services

[3] ACT Health. (May, 2024). *Challenging Behaviour Guidelines for Health Services*. Office of Professional Leadership and Education, (v 1.2: AHDPD-20:2020), p. 16.

*Recovery within forensic settings is highly individualised, requiring staff and consumers to address not only mental health needs but also coming to terms with having offended, and the social and personal consequences of that behaviour.*

Consumers strongly objected to this statement and described it as stigmatising because it assumes that all consumers receiving treatment in forensic inpatient services are morally culpable offenders. There are multiple issues with this. Firstly, as outlined in Section 6.2, not all consumers who receive treatment at Dhulwa are there due to having committed an offence. For instance, consumers may merely be charged with an offence pending trial and judgement. Alternately, others may not be charged with any offence and may simply be receiving care after transfer from another adult mental health inpatient facility. Secondly, even if a consumer is serving a sentence, this fact by itself does not mean that a consumer's recovery necessarily requires coming to terms with having offended due to morally culpable behaviour. Thirdly, framing recovery in forensic in-patient services in this way implies that a consumer's recovery journey necessarily requires progressing toward or achieving moral rectitude.

Consumers acknowledged that offence recovery is a key feature of forensic inpatient services. However, they maintained that centring this assumption in the MoC prejudices the care model and de-emphasises the individualisation of care planning. Consumers stressed that it may be the case for individual consumers that their recovery journey *does* involve coming to terms with perpetrated offences. They nevertheless stated that this should be addressed on a case-by-case basis and not framed in the MoC as the default assumption. Due to this, consumers recommended removing the above statement from the MoC.

### *Training requirements*

For the Policy Forum, consumers were provided with both the MoC and the FMoC v1.3. Comparing these two documents, consumers were concerned by the changes in Section 10.1 (p. 21) of the MoC. Consumers noted that the FMoC v1.3states that a "comprehensive training program is required to implement the MoC effectively" (p. 22). They highlighted that the new version of the MoC does not include in its list of key training;

- proactive risk mitigation;
- de-escalation techniques and limit setting;
- developing therapeutic relationships;
- supporting diverse and intersecting needs; nor
- supporting people with co-occurring disability and AOD use.

Consumers stated that it is important for a clear list of the training requirements to be included in the MoC as it sets the standard that CHS, staff, consumers and the public can expect from the service. Consumers therefore recommended retaining the original list of training requirements from the FMoC v1.3 in the MoC.

**Recommendations**

Recommendation 1:

In Section 8.1 (pp. 16-17), reinforce the MoC's commitment to upholding consumer rights in risk assessment and management decision making. A statement, such as the following, can be added at the end of the page 16:

> *All risk assessment and management decision making takes consumer rights and recovery goals into consideration alongside risk mitigation and safety stipulations.*

Recommendation 2:

In Section 8.3 (pp. 17-18), explicitly affirm the MoC's commitment to only using leave and access restrictions for the purposes of risk management and safety reasons. The following statement can be added to the first paragraph:

> *Decisions to restrict leave and access to activities and property will not be taken for punitive purposes and will only be employed in accordance with risk assessment, risk management and safety considerations.*

Recommendation 3:

In Section 7 (p. 15), affirm the MoC's commitment to upholding consumer rights regarding medication management and a second psychiatric opinion. A statement, such as the following, can be added to the third paragraph of this section:

> *Care planning collaboration with consumers will include navigating and managing medication side effects and, where requested, the provision of a second psychiatric opinion.*

Recommendation 4:

In Section 7 (p. 15), emphasise the consideration that care planning will give to individualised withdrawal and addiction management. The following statement is an example that could be added at the end of the second paragraph:

> *Individualised care planning includes appropriately supporting consumers' health needs, such as withdrawal and addiction management, and takes into consideration their rights and recovery goals.*

Recommendation 5:

In the Safety and Security section (pp. 18-20), add a subsection either before or after the Safewards subsection that addresses the use of restrictive intervention practices as a part of the MoC. This subsection should:

- Explicitly acknowledge the nationally recognised principle of reducing and, where possible, eliminating the use of restrictive practices as a priority for risk management and harm minimisation (see footnote 2 for relevant sources);
- State that restrictive intervention practices are only to be employed as a measure of last resort where first resort options have been exhausted or are unfeasible; and
- Explicitly state what approaches are to be considered and employed as first-resort options prior to escalating to restrictive intervention practices (see footnote 3 for relevant sources).

Recommendation 6: The Monitoring and Evaluation section (pp. 27-28) should be reviewed to ensure that all restrictive intervention practice notification and reporting obligations are included in the key performance indicators table.

Recommendation 7:

In Section 6.1 (p. 10), the following statement should be removed from the MoC:

> *Recovery within forensic settings is highly individualised, requiring staff and consumers to address not only mental health needs but also coming to terms with having offended, and the social and personal consequences of that behaviour.*

Recommendation 8:

In the Training and Education subsection (p. 21), the original list of training requirements contained in the FMoC v1.3 (p. 22) should be retained so that the following items are included in the MoC:

- proactive risk mitigation;
- de-escalation techniques and limit setting;
- developing therapeutic relationships;
- supporting diverse and intersecting needs; and
- supporting people with co-occurring disability and AOD use.

**Editorial recommendations**

The numbering of sections is incorrect from the Safety and Security section onwards in both the table of contents and the body of the MoC. The numbering of sections

needs to be corrected.

**Conclusion**

Consumers welcomed the opportunity to provide feedback on the MoC. The recommendations presented here are intended to enhance the MoC by improving clarity, consistency and safety for both consumers and staff. The Network looks forward to future collaborations with MHJHADS and would welcome an opportunity to view the final document.