HCASA
Health Consumers Alliance of SA Inc

Consumers at the centre of health in South Australia

HCA Response to Review of the Restraint and Seclusion in Mental Health Services Policy Guideline and Associated Documents

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Restraint and Seclusion In Mental Health Services in South Australia

Contents

Background 2

1. What information needs to or should be updated 2

2. Any new, recent evidence of importance or relevance to be taken into account 6

3. What other issues or matters should be included in the toolkit as fact sheets and advice about experts in these fields to assist in their development 8

Conclusion 8

HCA acknowledges the Traditional Custodians of Country. We pay respect to Elders past and present, and recognise that their cultural heritage, beliefs and relationship to Country are important for sustaining health and wellbeing.

Background

Health Consumers Alliance of South Australia (HCA) hcasa.asn.au

HCA is the peak body for health consumers in South Australia. We work with consumers and health services to position consumers at the centre of care. This work includes training and support to enable consumers and health professionals to collaborate in the design, delivery and evaluation of health policy, services and research.

In February 2018 HCA was invited by the South Australian Office of the Chief Psychiatrist to participate in a review of the *Restraint and Seclusion in Mental Health Services Policy Guideline*. Additionally, two Chief Psychiatrist Standards were being reviewed at the same time. These standards are: *Restraint and Seclusion – Recording and Reporting*; and *Restraint and Seclusion – Application and Observation Requirements*.

For the review HCA was asked to provide comment on:

- what information needs to or should be updated
- any new, recent evidence of importance or relevance to be taken into account
- what other issues or matters should be included in the toolkit as fact sheets and advice about experts in these fields to assist in their development
- any learnings or advice arising from practical application of the Policy Guideline and associated documents; and
- any other information you wish to provide

Other reviews, such as the *Oakden Review*, are also being considered for their potential impact on the Policy Guidelines and associated documents.

HCA notes that the Policy Guideline supports SA Health staff *to implement the SA Health Restraint and Seclusion Reduction Policy Directive; meet relevant legislative requirements; guide the development of restraint and seclusion reduction programs; ensure that when restraint or seclusion is used a person's rights and dignity ae maintained; and ensure that a review process occurs to assist in preventing further incidents of restraint and seclusion*

With this in mind HCA makes the following recommendations.

1. What information needs to or should be updated

1.1 A commitment to minimising, or eliminating where possible, restrictive practices be made explicit in the Policy Guideline and associated documents.

The Policy guideline states that *Restraint and seclusion are interventions of last resort* which makes a partial stand about the minimisation of their use. HCA believes that a stronger position that reiterates the wording in the *Minimising Restrictive Practices in Health Care Policy Directive* would be beneficial. This offers consistency of messaging to staff about practice and their role in prevention and proactively exploring other ways to engage with and support people who access mental health services.

Words used in the Policy Directive are, *This policy directive outlines the requirements for SA Health services to act on: minimising, or eliminating where possible, the use of restrictive practices; and meeting requirements to practice safely and lawfully if restraint or seclusion are applied during a period of health care.*

1.2 The Policy Guideline and associated documents are written in a more person-centred way.

Understanding the needs and preferences of consumers and carers is at the heart of person-centred care as well as prioritising the relationship that develops between people seeking care and those providing it. Person-centred care is also knowing how people like to be engaged with and what has been helpful for them before.

Whilst *Mandatory Requirement 4 – Services are person centred at all times* raises the importance of person-centred care HCA believes that the document and the practice elements detailed within it, must be person-centred as a whole. Person-centred care must permeate through all aspects of the policy guideline and associated documents rather than in a couple of paragraphs.

Person-centred care in a mental health context must be recovery-focused, a practice that HCA recommends be given more attention in this Policy Guideline.

Person-centred care, as conceptualised by the Australian Commission on Safety and Quality in Health Care's *Patient-Centred Care* report, is defined as, *Patient-centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers. The widely accepted dimensions of patient-centred care are respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of family and carers, and access to care*.[1]

1.3 The description and information provided around trauma-informed care better represent the experiences of people who access services and the evidence.

The inclusion of a trauma-informed care approach in this Policy Guideline is welcome and necessary, however the depth of information and the way it is described could be better articulated. In this section the sentence *People presenting to Mental Health Services endorse high rates of past trauma* would be better written as 'people who present to mental health services frequently experience high rates of past trauma'. Historical trauma is an experience that people have rather than something that they endorse or welcome.

HCA recommends that within the trauma-informed care section broader evidence about how a trauma-informed care approach benefits everyone, not just people who have experienced past trauma, be included. This would alleviate any concern that such an approach is used only with people known to have experienced past trauma or that invasive

[1] Australian Commission on Safety and Quality in Health Care (2011), *Patient-centred care: Improving quality and safety through partnerships with patients and consumers*, ACSQHC, Sydney.

questions are asked to determine this before engaging with them in a trauma-informed way.

In the US the National Center for Trauma-Informed Care encapsulates these differences,

A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing[2].

1.4 More care and consideration is given to the language and framing of some elements of the Policy Guideline.

HCA suggests that the language within the Policy Guideline is changed to be more person-centred and recovery-focused than it currently is. Several examples of this are:

- Within the person-centred care section, page 7 of 29, a focus on any type of feedback, and not just complaints about a person's care and treatment, is important.
- Within the *availability of meaningful activities* section, page 8 of 29, the options available are said to vary due to *the environment and clientele within the environment*. A different way of writing about what the options available depend on may be 'the environment, care context, resourcing and preferences of the consumer'.
- Within the mandatory requirement section on programs, page 8 of 29, reference is made to the level of functioning of a person in determining their program. HCA recommends that this is rewritten to focus on a consumers' capacity to engage with activities and programs at any given point in time.
- Within the Culturally and Linguistically Diverse section, page 19 of 29 the assumption that people from certain groups have substantial fear of authority figures and should therefore be monitored by security staff is one that impacts care immediately and is not person-centred.

1.5 More focus is put on the consumers capacity to monitor and regulate their own behaviour or that they do this in collaboration with staff.

Frequently throughout the Policy Guideline staff are given responsibility for de-escalation. When services are recovery-focused a person's autonomy and capacity for self-management is acknowledged and nurtured. HCA believes that this understanding and practices to support it must be included in the Policy Guideline.

[2] National Center for Trauma-Informed Care. (2015). Trauma-Informed Approach and Trauma-Specific Interventions. SAMHSA: Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/nctic/trauma-interventions

1.6 The role of engaging with carers be added to the Policy Guideline.

Throughout the Policy Guideline there is minimal mention of involvement of, or with a person's family, support person or carer. Increasingly the role of other people in a person's life and care is seen as an important element of care that must be addressed.

A practical guide for working with carers of people with a mental illness is a helpful resource for understanding this aspect and makes reference to the Triangle of Care Model[3]

1.7 Personal Prevention Plans (PPP) and Advanced Care Directives (ACD) be strongly recommended to complete with people in mental health services as a matter of course rather than relevant only some of the time.

As the Policy Guideline is currently written inconsistent practice and use of PPP would result. As a tool for providing better care and prevention of seclusion and restraint HCA recommends these be mandatory, or strongly recommended at a minimum, for people who access mental health services. This re-focuses these documents as an enhancement of care and supporting a person rather than as a means of avoiding restraint and seclusion which can be read as the intention from the current document.

Within the policy guideline clear directions regarding PPP and ACD accessibility to staff and review timelines will need to be included. This an implied outcome related to the *Oakden Review* and observations made within it.

1.8 The time people are restrained or secluded is reviewed in relation to best practice guidelines and valuing the rights of people to be free from harm.

Within the *Oakden Review* it was reported that in some states the time that people can be restrained is restricted by law to three hours which is at odds with the four hours currently allowed in South Australia. HCA recommends that this time review is investigated further and adjustments to the Policy Guideline made accordingly.

1.9 Equal focus must be on the legislative basis for restrictive practices as well as the human-rights of people to be free from harm within mental health services.

An Action Plan from Recommendation Six in the *Oakden Review* is to *ensure all staff are aware of the legislative basis for restrictive practices*. HCA recommends that this is matched with understanding the human-rights basis for not engaging in restrictive practices. This is one small way that the focus on restrictive practices can move from compliance to one of improvement and providing safe quality care.

[3] A practical guide for working with carers of people with a mental illness, March 2016, Mind Australia, Helping Minds, Private Mental Health Consumer Carer Network (Australia), Mental Health Carers Arafmi Australia and Mental Health Australia.

Through their *QualityRights* Initiative the World Health Organisation (WHO) offers extensive resources for supporting a recovery-focused and human-rights based approach within mental health services[4]

1.10 Chemical restraint be provided its own category of explanation within the Restraint and Seclusion Application and Observation Requirements Chief Psychiatrist Standard.

Within this Chief Psychiatrist Standard physical restraint, mechanical restraint and seclusion have their own sub-sections regarding their application and observation. With the increased awareness surrounding chemical restraint HCA recommends that this be addressed in its own right.

1.11 Consideration be given to simplifying the definition of restraint and seclusion in the Policy Guideline and associated documents.

Within the *Positive and Proactive Workforce* guide from the UK a simplified description of restraint and seclusion is used. HCA believes that such a definition is a more person-centred and compassionate explanation for understanding what these things are and the experience of people that may be subject to them. The definition that they use is, *Making someone do something they don't want to do or stopping someone doing something they want to do*[5]

2. Any new, recent evidence of importance or relevance to be taken into account

2.1 Restraint and seclusion as a human rights issue for people be a more clearly articulated theme throughout the Policy Guideline and associated documents.

This aligns with recommendations made by the UN High Commissioner for Human Rights in 2017, *the High Commissioner recommends a number of policy shifts, which would support the full realization of the human rights of those populations, such as the systematic inclusion of human rights in policy and the recognition of the individual's autonomy, agency and dignity. Such changes cover measures to improve the quality of mental health service delivery, to put an end to involuntary treatment and institutionalization and to create a legal and policy environment that is conducive to the realization of the human rights of persons with mental health conditions and psychosocial disabilities*[6]

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[4] WHO QualityRights guidance and training tools. Downloadable from:

http://www.who.int/mental_health/policy/quality_rights/guidance_training_tools/en/

[5] Skills for Care and Skills for Health. (2014). A positive and proactive workforce: A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health. Skills for Care UK: Leeds.

[6] United Nations High Commissioner for Human Rights. (2017). Mental health and human rights: Report of the United Nations High Commissioner for Human Rights. UN General Assembly: Human Rights Council Thirty-fourth session.

2.2 Every mention of restraint and seclusion not being therapeutic also include a statement regarding it as a potential source of harm and re-traumatisation.

HCA welcomes the clear statements made throughout the document regarding restraint and seclusion not being therapeutic. We recommend that the words *Restraint and seclusion are not therapeutic interventions* are partnered with 'and such practices are a potential source of harm and re-traumatisation, for both consumers and staff' each time they are stated.

2.3 Several of the core strategy areas the Policy Guideline is broadly structured around be strengthened, these being: the use of data to inform practice and workforce development.

The *Oakden Review*, for example, highlighted the *significance and seriousness of the excessive rate*[7] of restraint and the failure of SA Health staff to understand or take action to remedy it. HCA suggests it is within the scope of the *Restraint and Seclusion Recording and Reporting Chief Psychiatrist Standard* to have a mechanism in place to draw attention and recommend action for such excessive rates of restraint and seclusion.

Within the *Oakden Review* the lack of training of staff in prevention of restraint and seclusion and reduction tools and strategies was detailed. This is an area that must be addressed. HCA recommends that, at a minimum, equal training time be devoted to the prevention of restraint and seclusion practices as is currently committed to learning about secluding or restraining a person seeking care and treatment. The ideal would be that more time is spent on developing these skills and that they are developed first. The training and guidance tools within WHO's *QualityRights Initiative* will be useful resources to draw on.

Similar training recommendations were made in the A Positive and Proactive Workforce report from the UK, *Learning about human rights based, positive and pro-active, non-aversive approaches must precede any training on or use of restrictive interventions. Significantly more time should be spent learning about positive and pro-active approaches and non-restrictive alternatives. Any learning about how to carry out restrictive interventions should always focus on good practice where positive pro-active strategies are the norm and are part of an ongoing learning pathway*[8]

2.4 The Reducing Restrictive Practices Implementation Plan be drawn on in this review for actionable inclusions into a new Policy Guideline and associated documents.

A comprehensive *Reducing Restrictive Practices Implementation Plan* was developed in response to Recommendation Six of the *Oakden Review*. This Plan has detailed courses of action for minimising and eliminating restraint and seclusion. We suggest particular consideration be given to: the development of Comfort Plan's as a person-centred and prevention focused strategy; and to developing a *directory of Restraint Prevention Strategies* for staff access and education.

For the Policy Guideline currently being reviewed, HCA recommends that Comfort Plan's replace the PPP and that a fact sheet on Restraint Prevention Strategies be developed.

[7] Groves A, Thomson D, McKellar D and Procter N. (2017) The Oakden Report. Adelaide, South Australia: SA Health, Department for Health and Ageing.

[8] Skills for Care and Skills for Health. (2014). A positive and proactive workforce: A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health. Skills for Care UK: Leeds.

In considering the Implementation Plan, awareness of the different context that it was written for, that being Older Persons Mental Health Services, will need to be considered. Throughout the Plan the strategies for change are more carer focused than they would be in other mental health service contexts and the focus would need to return to the consumer.

3. What other issues or matters should be included in the toolkit as fact sheets and any advice about experts in these fields to assist in their development

3.1 A Trauma-Informed Care fact sheet be developed.

The US Substance Abuse and Mental Health Services Administration (SAMHSA) is an internationally recognised leader in trauma-informed practices and approach[9].

3.2 A Person-Centred Care within Mental Health Services fact sheet be developed.

Commission HCA, the Lived Experience Leadership & Advocacy Network (LELAN) and the Mental Health Coalition (MHCSA) to work in partnership to develop a contemporary version.

3.3 A flowchart fact sheet be developed to support staff reflection and decision-making on restrictive practices and the care they provide to people.

Attachment A has an example flowchart from the UK's Positive and Proactive Workforce guide.

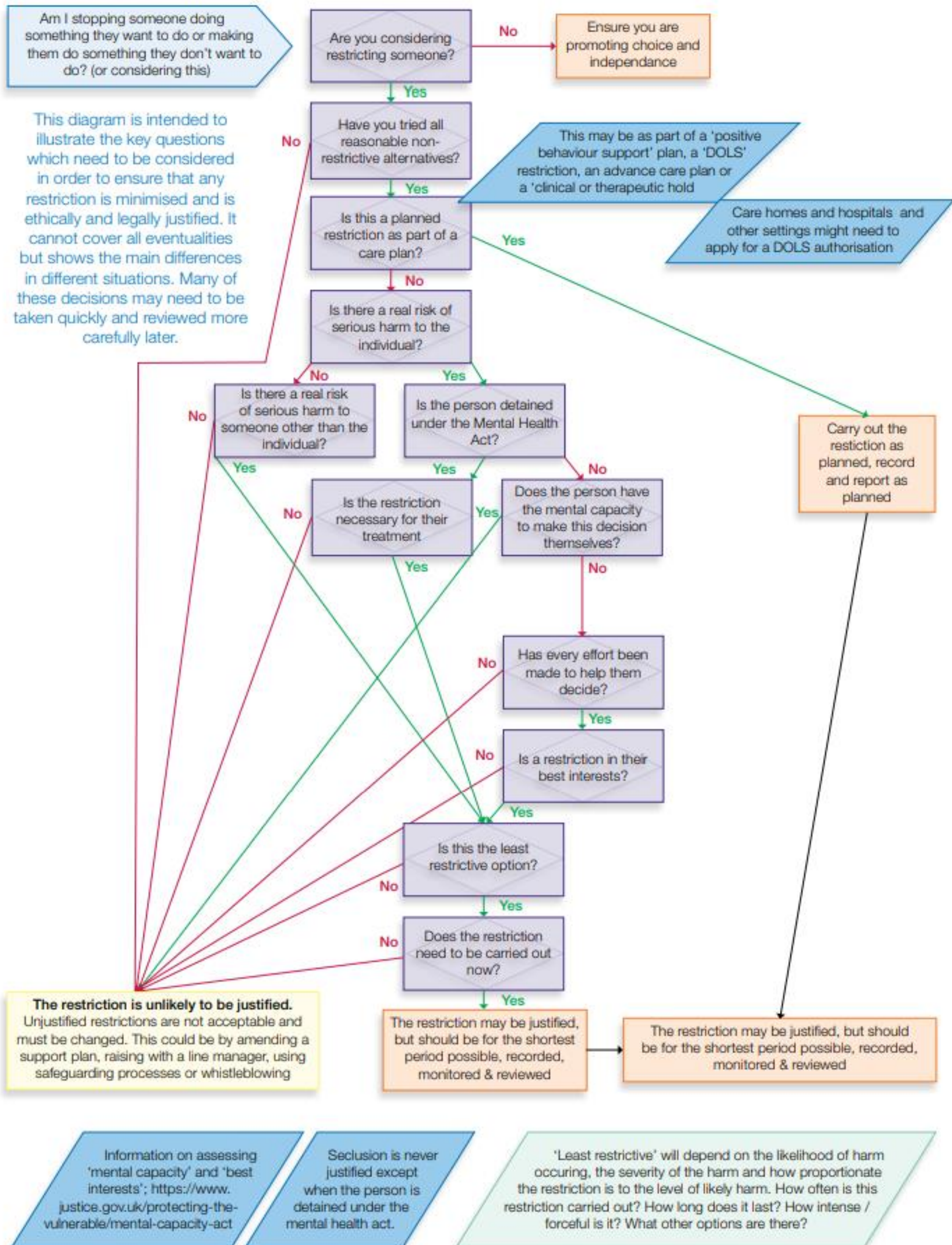
Conclusion

HCA has appreciated the opportunity to provide comment and contribute to the work of the Office of the Chief Psychiatrist. We welcome this Policy Guideline and associated documents review in the wake of recent attention and focus on restrictive practices within our state.

HCA is committed to placing consumers at the centre of health in South Australia. We therefore recommend that a person-centred, rights-based and trauma-informed approach to the minimisation and elimination of restraint and seclusion be endorsed.

[9] Substance Abuse and Mental Health Services Administration. *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Attachment A[10]



[10] Skills for Care & Skills for Health, A positive and proactive workforce. A guide to workforce development for commissioners and employers seeking to minimise the use of restrictive practices in social care and health, (Leeds, 2014)