Submission: Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities

September 2017

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The Mental Health Coordinating Council (MHCC) thanks the NSW Minister for Mental Health for providing us with the opportunity to comment on the Ministry of Heath's *"Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities."* [1]

MHCC appreciate the extended time-frame made available for submissions to be presented. We are also pleased to see that numerous consultations are being held to hear from people with lived experience of seclusion and restraint, as well a broader range of stakeholders across the mental health service system.

Legislative context

MHCC have long advocated that the intentions of the *Mental Health Act 2007* (NSW) (the Act) be more clearly defined with regards to restrictive practices and observation; both in the Principles for care and treatment (s68) and elsewhere under a newly written section. As it stands the *Mental Health Act 2007* (NSW) does not specifically regulate seclusion, physical or chemical restraint of patients. Nevertheless, it does state 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." (s68(f))

This principle is qualified by another section of the Act which provides that this principle, and any other part of the Act, does not prevent an authorised medical officer from taking an action the officer thinks fit, *"to protect a person detained in a mental health facility, or any other person in a mental health facility (such as a staff member or visitor) from serious physical harm*.*"* [2]

In reality, restrictive practices such as seclusion, sedation and physical restraint are used regularly in NSW mental health facilities to manage the perceived risks associated with people who exhibit behaviour challenging to staff. The legal basis on which these interventions are justified is the common law duty of care owed to the *"patient himself or herself, to other patients and visitors, and to staff, to prevent serious and imminent physical harm."* This duty of care must be exercised reasonably and proportionately in terms of the actual risk involved.

Policy context

NSW Health's current policy (PD2102_35) on the use of both seclusion and restraint in psychiatric hospitals is titled: '**Aggression, seclusion and restraint in Mental Health Facilities in NSW'**. In the first instance MHCC propose reconsideration of the policy document's title. MHCC urge that the concept of 'safety for all' be reflected in the title. In other words, something to the effect *"**Towards elimination of restrictive practices in NSW mental health facilities."***

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[1] NSW Health 2017, Review of seclusion, restraint and observation of consumers with a mental illness in NSW Health, Available: http://www.health.nsw.gov.au/patients/mentalhealth/Pages/terms-of-reference.aspx
[2] *Mental Health Act 2007* (NSW), Available: http://www.health.nsw.gov.au/patients/mentalhealth/Pages/terms-of-reference.aspx

The policy includes (in an appendix)[3] seven key principles that inform the use of restraint and seclusion. These principles include: protection of fundamental human rights; protection against inhumane or degrading treatment; the right to highest attainable standards of care; and, the right to medical examination. The policy also places major emphasis on the reduction, and where possible, the elimination, of the use of seclusion and restraint in public mental health services and the use instead of hands-off and non-coercive de-escalation strategies.

Likewise, the policy seeks to avoid the risk of trauma and re-traumatisation, injury and death to patients and others that may be associated with the use of seclusion and restraint. It also seeks to ensure that these interventions, when they are used, are guided by the following principles:

- The safety and wellbeing of the person is vital
- The safety and wellbeing of staff is vital
- Seclusion and restraint is used for the minimum period of time
- All actions undertaken by staff are justifiable and proportional to the consumer's behaviour
- Any restraint used must be the least restrictive to ensure safety
- The consumer is closely reviewed and monitored so that any deterioration in their physical condition is noted and managed promptly and appropriately.

The policy requires that seclusion not be used in the following circumstances:

- When the consumer is actively self-harming
- As a routine procedure when a consumer is abusive, threatening or destructive of property
- As a routine procedure following physical restraint
- As a low stimulus environment – other options must be trialled first
- To prevent a consumer absconding from a mental health unit
- As a punishment or threat

Whilst these principles and guidelines reasonably describe what to do and what not to do, they do not go far enough in terms of ensuring human rights or demonstrating the values and principles of a Trauma-informed Care and Practice (TICP) approach. These principles need to be clearly articulated and embedded in the body of the policy document (see this submission, Appendix 1). At this point in time, they are only somewhat evident in the Policy Appendix 5: *Core Education and training priorities* and Appendix 7: *Seclusion Practices Audit*. In merely stating the importance of being trauma-informed, the document doers not elaborate or articulate what this means in terms of principles or a practice approach. Similarly, the current NSW Health Policy: A*ggression, Seclusion and Restraint in Mental Health Facilities in NSW* emphasises the role of prevention and the use of a range of therapeutic interventions to reduce seclusion and restraint (page.8) whilst not articulating what those are.

There are a number of trauma-informed questions that speak to additional therapeutic interventions that are also important to include. Examples of these can be demonstrated when trauma-informed services recognise that trauma profoundly affects a person's sense of safety with others and in the environment, and that negotiating and maintaining safety is critical so that a person is able to participate in what a service has to offer. Practitioners might for example reflect on whether:

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[3] NSW Health 2012, Policy Directive, Aggression, seclusion and restraint in Mental Health Facilities in NSW'http://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_035.pdf

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- Consumers are routinely asked if they feel safe in the service environment

- Discussion of safety with consumers is not limited to an absence of identifiable threat, but incorporates a subjective assessment of resources required by consumers to feel safe

- Discussion regarding safety clearly incorporates the dimensions of psychological, emotional and cultural safety (i.e., is not limited to physical safety) (TICPOT, Domain B: Organisational Policies & Structure).[4]

In this context, of concern to MHCC is what happens to people brought into emergency departments (EDs), and how events can escalate into critical incidents. Our understanding is that whilst there may be safe assessment rooms in EDs, these may not represent opportunities for de-escalation where care can be provided with dignity in a trauma-informed way. Often events will give rise to security responses that utilise restrictive practices, inevitably exacerbating fear and resulting in 'difficult' and 'uncooperative' behaviours on the part of the 'patient'.

Police typically bring people to EDs rather than Psychiatric Emergency Care Centres (PECCs). We understand that PECC Guidelines are non-binding, and that they are free to operate in accordance with local need; therefore generalisations are hard to draw. This is described in the Guidelines as:

> *"It is neither desirable nor possible to standardise resourcing, service delivery arrangements or facilities for managing the care of persons with mental health problems. Earlier versions of the PECC Model of Care Guidelines have attempted to articulate a consensus regarding detailed aspects of PECC operations. However it has become apparent that the preferred approach is that this Model of Care Guideline provide a relatively high level set of guiding principles and basic components from which each service can develop and monitor their own more detailed operating procedures and governance processes which will contribute to best patient care and to the structure of each services' model of care."* [5]

What MHCC understand is that PECCs are generally used to support people experiencing a lower level of acuity, referred via triage between ED and Mental Health and described as a person demonstrating vulnerability; such as a young person, or a person with an intellectually disability. Theoretically, the time limit is 72 hours but in fact we understand that some PECCs include a short stay unit or Short-Term Acute Care (TAC)where a person may end up staying five or six days.

In the absence of alternative places that police or carers or family can take a person to (when thought to be a risk to themselves or others), MHCC strongly advocate access to a safe de-escalation environment in every ED. This must be accompanied by access to highly trained staff utilising a trauma-informed approach, to ensure that people can be given the opportunity to be cared for in a way that minimises the likelihood of restrictive practices, scheduling and stays in acute facilities; which can lead to poor engagement with services and becoming trapped in a revolving door of admission, discharge, and readmission.

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[4] Mental Health Coordinating Council Inc. (MHCC) 2015, The Trauma-Informed Care and Practice Organisational Toolkit (TICPOT): An Organisational Change Process Resource, Stage 1 - Planning and Assessment, Authors: Henderson, C , Everett, M & Bateman, J, Available to purchase: http://www.mhcc.org.au/sector-development/recovery-and-practice-approaches/ticpot.aspx
[5] NSW Health 2015, Psychiatric Emergency Care Centre Model of Care Guideline, PD2015_009.

In this context we highlight the need to improve support mechanisms for people following crises, this includes collaboration and partnership between EDs and community-managed services to facilitate post-crisis referrals. Characteristically, when a person is discharged straight from an ED, they may have little or no support available to them that might reduce the likelihood of further crises or readmission. An 'Open Dialogue' approach to integrated care is a model that can be applied in such contexts (Seikkula, 2003).[6] Open dialogue is an approach that can integrate an individual and systemic approach, even in an emergency setting.

> *"Even if the client were acutely unwell, clinicians would see the crisis as an opportunity to help the client and social network increase their understanding and open up dialogue about what has happened and the meaning they have drawn from their experiences. Crises would be seen as opportunities in which the emotions and issues are revealed and available to be addressed in therapeutic interventions."* [7]

Trauma-informed care and practice (TICP)

TICP is an approach to mental health and human services that recognises the high prevalence of prior and ongoing trauma in the lives of people who use these services (on either a voluntary or an involuntary basis). The approach also acknowledges the serious neurological, biological, psychological and social impacts of trauma of any kind on the individual.

Trauma occurring in the context of interpersonal violence, either covert or overt, often results in complex and chronic psychological and physiological injuries. Such trauma includes the experience of violence and victimisation, including sexual, emotional and physical abuse, neglect, loss, and domestic violence including witnessing domestic violence, torture, terrorism and war. Many such experiences that occur in childhood particularly can produce intense fear and extreme stress responses in the person, as well as feelings of helplessness, hopelessness and an inability to cope.

Trauma-informed practice involves mental health practitioners adopting 'universal precautions' to avoid triggering trauma responses and creating further trauma. It calls for the consideration (and where appropriate assessment) of symptoms concurrently with other interventions, and avoidance of interventions that are traumatising or re-traumatising for example: restraint, seclusion and involuntary detention and treatment; and ensuring as far as is possible collaborative practice and power sharing between the practitioner and the patient/consumer and the individual's personal support network; as well as careful use of objective neutral language to describe situations; and, an understanding of the function of behaviour as a coping adaptation.

The process of becoming trauma-informed is unique to each organisation/ service and needs to be tailored. However, a universal aim is to establish a cultural shift that embeds principles and adopts a practice approach that will ultimately become second nature in an organisation and workforce. It is an evolutionary journey, and audit processes can be scheduled as part of an action plan to measure short-term and longitudinal cultural change.

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[6] Seikkula J 2003, Open dialogue integrates individual and systemic approaches in serious psychiatric crises, Smith College Studies in Social Work, 73: 227-245.

[7] Burbach, FR 2013, *Developing Systemically-oriented Secondary Care Mental Health Services*, Plymouth.

The **Trauma-Informed Care and Practice Organisational Toolkit** (TICPOT) **[8]** is an organisational change process resource that guides an organisation though a process of becoming trauma-informed. Initially it invites participants to look at their organisation across organisational domains, as applicable to their service setting. These domains shown in the diagram (on p. 9 of this submission) identifies seven areas that may be relevant to a particular service, program, department etc., these are: A. Governance, Management and Leadership; B. Organisational Policies and Structure; C. Consumer and Carer/Family Participation; D. Direct services to Consumers; E. Healthy and Effective Workforce; F. Information and Education and G. Outcomes and Evaluation. Each domain incorporates a range of audit questions that span across these service delivery contexts. Elements of the tool can be included as part of a policy and practice audit/ reflective process which can assist services to support their ongoing journey towards transforming their service delivery culture.

Consisting of two separate resources, TICPOT contains a **User Guide, Stage 1: Planning and Assessment.** It provides a brief overview and an organisational audit/assessment tool across the seven domains. It describes the processes necessary to assist ongoing, sustainable quality improvement. The second document **Stage 2: Supporting Organisational Change** provides some materials and resources to assist the building of a trauma-informed culture and practice approach that supports staff and the consumers and carers engaging with the service.

The tool is mapped against the National Standards for Mental Health Services 2010 (NSMHS); the National Practice Standards for the Mental Health Workforce 2013 (NPSMHW); the National Standards Disability Services 2013 (NSDS) as well as MHCC's *Recovery-oriented services self-assessment organisational tool* (ROSSAT, T4O).[9]

An example from the audit resource TICPOT Domain A. Governance, Management and Leadership, looks at how trauma-informed the organisation, service or program etc., is in terms of its governance, management and leadership. It proposes a point of responsibility to be clearly identified within the organisation, charged with fostering the changes required to implement trauma-informed principles and practice, underpinned by a clear framework and time-frame for quality improvement and implementation processes across the organisation. Under this leadership a Working Group would be established from across various roles and responsibilities in the organisation, and include consumer/ carer participation.

3. Knowledge of trauma and trauma-informed practice amongst leaders and managers *All people in the organisation need knowledge concerning the impact of trauma and trauma-informed care, including managers and leaders providing direction for organisational change.*[1]
• All managers and leaders have participated in training and education about the incidence, prevalence and impact of trauma across the lifespan
• All managers and leaders have participated in training and education regarding trauma-informed care and practice, policy and procedures
• Managers and leaders have an understanding of trauma-informed principles and practice and encourage staff at all levels to participate in training and education about the incidence, prevalence and impact of trauma
• Managers and leaders provide clear direction regarding organisational change required to implement a trauma-informed practice approach
• Managers and leaders provide clear leadership in how to reduce the use of coercive and restrictive practices with the organisation

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[8] Mental Health Coordinating Council Inc. (MHCC) 2015, *The Trauma-Informed Care and Practice Organisational Toolkit (TICPOT): An Organisational Change Process Resource, Stage 1 - Planning and Assessment,* Authors: Henderson, C , Everett, M & Bateman, J, Available to purchase: http://www.mhcc.org.au/sector-development/recovery-and-practice-approaches/ticpot.aspx
[9] Ibid.

5. Organisational Mission
The organisation and staff understand and support embedding trauma-informed principles, in the mission of the organisation. This provides a focus and vision that directs every aspect of an organisation's undertakings.
If the organisation provides direct services to individuals from populations which have a high prevalence of trauma: • The mission statement refers directly to the organisation's responses to people who have experienced trauma
• The organisation has a documented commitment to trauma-informed practice and communicates this to consumers, carers/families and staff in numerous formats including written information
For all organisations: • Staff are aware of the organisation's mission and actively engage in supporting and delivering on its purpose
• The organisation's mission statement is accessible publicly
• The organisation has clear value statements regarding consumer rights and the promotion of self-determination

Another example from the TICPOT audit resource shown below is Domain E. Healthy and Effective Workforce, which includes questions regarding staff selection and retention, staff orientation, workforce development and training, staff wellbeing and supervision. This domain proposes that all human resource development activities should: reflect understanding of and sensitivity to issues of violence, trauma and coercion; incorporate relevant skill sets and job standards; and address the prevalence and impact of traumatic events.

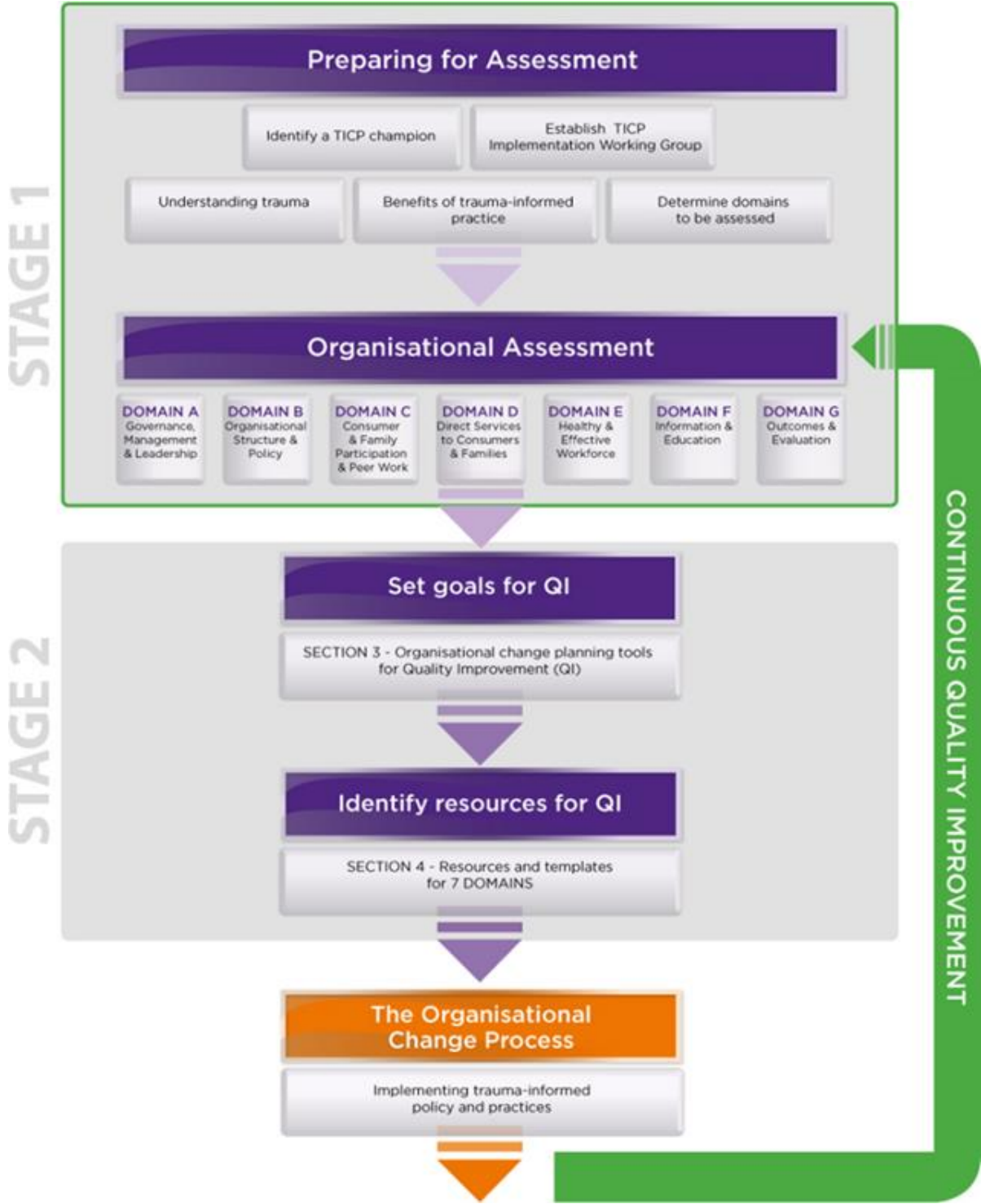| 1. Staff selection and orientation |
|---|
| *Trauma-informed organisations select and prepare staff members who are able to a) implement the core values of the organisation and b) promote trauma-informed practice.* |
| • Questions reflecting the principles and values of trauma-informed care are asked at interview for all direct service provision staff |
| • The staff selection process prioritises safety and communication skills |
| • The staff selection process is transparent and accountable |
| • During the staff selection process staff are made aware that they will be working with people affected by trauma |
| • The staff selection and orientation process emphasises teamwork and respect for diversity amongst colleagues |
| • All staff are provided with induction training or orientation to the organisation's values/model of operation including the principles of trauma-informed care and practice, prior to direct contact with consumers [2] |

TICPOT provides a process akin to a reflective audit rather than a traditional assessment or accreditation process. It sets out to identify priorities for quality improvement to be addressed in stages, and to develop a course of action that prioritises specific areas over-time. The idea is to support best-practice in a way that an organisation can comfortably accommodate. This may include in-house training across workforce roles as well as other development strategies such as: supervision incorporated into clinical governance processes and protocols.

TICPOT identifies seven organisational domains. Some domains are only relevant to particular types of services, organisations or programs. Through the audit process, users of the toolkit will identify a course of action that prioritises different areas for quality improvement according to their identified priorities.

Transformation of policy and practice is expected to improve the quality of life, psychosocial and health outcomes for all people engaging with public and community services including the workforce. However, a service, program or organisational system is likely to experience limited capacity to assess its transformational impact on individuals, families, and communities unless it has the ability to include an assessment process that reflects on how it is travelling. Therefore reporting outcomes is an integral part of the TICP implementation process.

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The TICPOT Model of Organisational Audit and Implementation

STAGE 1

Preparing for Assessment

- Identify a TICP champion
- Establish TICP Implementation Working Group
- Understanding trauma
- Benefits of trauma-informed practice
- Determine domains to be assessed

Organisational Assessment

DOMAIN A	DOMAIN B	DOMAIN C	DOMAIN D	DOMAIN E	DOMAIN F	DOMAIN G
Governance, Management & Leadership	Organisational Structure & Policy	Consumer & Family Participation & Peer Work	Direct Services to Consumers & Families	Healthy & Effective Workforce	Information & Education	Outcomes & Evaluation

STAGE 2

Set goals for QI

SECTION 3 - Organisational change planning tools for Quality Improvement (QI)

Identify resources for QI

SECTION 4 - Resources and templates for 7 DOMAINS

The Organisational Change Process

Implementing trauma-informed policy and practices

CONTINUOUS QUALITY IMPROVEMENT

Alternatives to seclusion and restraint

In addition to utilising TICPOT to reflect on current processes and practices in services that may reduce crises leading to seclusion and restraint, MHCC draw the Review's attention to the extensive work of the Substance Abuse and Mental Health Services Administration (SAMHSA) in the USA. Studies emanating from this source have shown that "*the use of seclusion and restraint can result in psychological harm, physical injuries, and death to the people subjected to these restrictive practices*" as well as serious vicarious trauma to staff applying these techniques.[10] Restraints can be harmful and often re-traumatising for people, especially those who have trauma histories. "*Beyond the physical risks of injury and death, it has been found that people who experience seclusion and restraint remain in care longer and are more likely to be readmitted for care.*"[11]

SAMHSA has committed to reducing and ultimately eliminating the use of seclusion and restraint practices in organisations and systems serving people with mental and/or substance use disorders.[3] Their stated goal is to create "*coercion and violence-free treatment environments governed by a philosophy of recovery, resiliency, and wellness.*" Successful efforts have eliminated these practices across the USA in a number of mental health, rehabilitation and community based service settings and programs including psychiatric hospitals, forensic psychiatric facilities, residential treatment centres, and jails and criminal justice settings. MHCC propose that NSW Health similarly commit to this goal.

SAMHSA have provided a number of resources that support their position and MHCC direct the Ministry to these:

- SAMHSA's [Promoting Alternatives to the Use of Seclusion and Restraint Issue Brief #1: A National Strategy to Prevent Seclusion and Restraint in Behavioral Health Services — 2010 (PDF | 498 KB)](): This issue brief provides information on the history of seclusion and restraint and efforts to reduce and eliminate these practices.

- SAMHSA's [Promoting Alternatives to the Use of Seclusion and Restraint Issue Brief #2: Major Findings From SAMHSA's Alternatives to Restraint and Seclusion State Incentive Grants (SIG) Program — 2010 (PDF | 431 KB)](): This issue brief summarizes evaluation data from the first cohort of the Alternatives to Restraint and Seclusion SIG program.

- SAMHSA's [Promoting Alternatives to the Use of Seclusion and Restraint Issue Brief #4: Making the Business Case — 2010 (PDF | 548 KB)](): This issue brief summarizes a white paper that describes the systemic, organizational, and personal costs of the continued use of seclusion and restraint practices, as well as cost savings related to reducing the use of these practices.

- SAMHSA's [Roadmap to Seclusion and Restraint Free Mental Health Services — 2006](): This training manual explores sustainable solutions and strategies for eliminating the use of seclusion and restraint in the treatment of people with mental illnesses and children with serious emotional disturbances.

- SAMHSA's [The Business Case for Preventing and Reducing Restraint and Seclusion Use — 2011](): This white paper examines the economic impact of restraint and seclusion within organizations. It creates a business case for reducing these practice.

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[10] SAMHSA 2017, Alternatives to Seclusion and Restraint Website, Available: https://www.samhsa.gov/trauma-violence/seclusion and https://www.samhsa.gov/topics/trauma-violence/samhsas-trauma-informed-approach
[11] Ibid.

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- [Restraint and Seclusion: Resource Document from the Department of Education — 2012 (PDF | 1.5 MB)](): This document describes 15 principles for states, school districts, schools, parents, and other stakeholders to consider when developing or revising policies and procedures on the use of restraint and seclusion with students.

- [Six Core Strategies to Reduce Seclusion and Restraint Use from the National Association of State Mental Health Program Directors (NASMHPD) — 2008](link is external): This document outlines six core seclusion and restraint reduction strategies. It includes a planning tool to guide the development of a seclusion and restraint reduction plan and an example of debriefing policies and procedures.

- [The New York State Office of Mental Health Positive Alternatives to Restraint and Seclusion (PARS) Project from *Psychiatric Services* — 2015](link is external): This journal article discusses the implementation and outcomes of the Positive Alternatives to Restraint and Seclusion (PARS) project in three mental health treatment facilities in New York.

MHCC emphasise here that whilst NSW mental health services must commit to reducing and ultimately eliminating the use of seclusion and restraint practices that the best practice approach is to ensure that people living with mental health conditions have access to community-based mental health services that support them to remain well in the communities of their choice.

Whilst we recognise the importance of increased investment in EDs as effective de-escalation and referral facilities, we urge Government to not just see the problem of seclusion and restraint as starting at the door of the emergency department, or when a person is picked up by police. Government must commit to building the capacity of the community-based workforce and employing people with the skills and expertise to minimise use of emergency departments and acute hospital care. Vital to the success of such a commitment is local level collaboration and cooperation, between community-managed and public mental health services, primary health care and the police; and for there to be a concerted effort to rebalance investment from the hospital to community support options as identified in the *Living Well: A Strategic Plan for Mental Health in NSW* (NSW Mental Health Commission, 2014).[12]

Practice Standards

MHCC strongly urge amendment to the national practice standards. The standards should include the Principles of Trauma-Informed Care and Practice (Appendix 1). As mentioned earlier, the TICP Toolkit is mapped where relevant to the following quality and practice standards (see diagram following), allowing organisations to clearly understand where they are meeting or progressing towards benchmarks.

Recovery Oriented Service Self-Assessment Toolkit 2015 (ROSSAT T4O)	National Standards for Mental Health Services 2010 (NSMHS)	National Practice Standards for the Mental Health Workforce 2013 (NPSMHW)	National Standards Disability Services 2013 (NSDS)
✓	✓	✓	✓

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[12] NSW Mental Health Commission 2014, 'Living Well: A Strategic Plan for Mental Health in NSW', Sydney, NSW Mental Health Commission. Available: https://nswmentalhealthcommission.com.au/sites/default/files/Living%20Well%20-%20A%20Strategic%20Plan%20full%20version.pdf

In regards to mental health crises, SAMHSA have provided comprehensive Practice Guidelines with which to respond. In these Guidelines they recommend a set of ten essential values [13] [14] that are "*inherent in a crisis response, regardless of the nature of the crisis, the situations where assistance is offered or the individuals providing assistance.*" These comfortably align with TICP principles and practice which are outlined in the TICPOT Stage 1 resource, and provide a practical response in a specific context where crises occurs:

1. **Avoiding harm.** *An appropriate response to mental health crises considers the risks and benefits attendant to interventions and whenever possible employs alternative approaches, such as controlling danger sufficiently to allow a period of "watchful waiting." In circumstances where there is an urgent need to establish physical safety and few viable alternatives to address an immediate risk of significant harm to the individual or others, an appropriate crisis response incorporates measures to minimise the duration and negative impact of interventions used.*

2. **Intervening in Person-centred ways.** *Appropriate interventions seek to understand the individual, his or her unique circumstances and how that individual's personal preferences and goals can be maximally incorporated in the crisis response.*

3. **Shared responsibility.** *An appropriate crisis response seeks to assist the individual in regaining control by considering the individual an active partner in—rather than a passive recipient of—services.*

4. **Addressing trauma**. *It is essential that once physical safety has been established, harm resulting from the crisis or crisis response is evaluated and addressed without delay by individuals qualified to diagnose and initiate needed treatment. There is also a dual responsibility relating to the individual's relevant trauma history and vulnerabilities associated with particular interventions; crisis responders should appropriately seek out and incorporate this information in their approaches, and individuals should take personal responsibility for making this crucial information available (for instance, by executing advance directives).*

5. **Establishing feelings of Personal safety.** *Assisting the individual in attaining the subjective goal of personal safety requires an understanding of what is needed for that person to experience a sense of security (perhaps contained in a crisis plan or personal safety plan previously formulated by the individual) and what interventions increase feelings of vulnerability (for instance, confinement in a room alone). Providing such assistance also requires that staff be afforded time to gain an understanding of the individual's needs and latitude to address these needs creatively.*

6. **Based on strengths.** *An appropriate crisis response seeks to identify and reinforce the resources on which an individual can draw, not only to recover from the crisis event, but to also help protect against further occurrences.*

7. **The whole Person.** *An individual with a serious mental illness who is in crisis is a whole person, whose established psychiatric disability may be relevant but may—or may not—be immediately paramount. That the individual may have multiple needs and an adequate*

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[13] SAMHSA 2009, Practice Guideline: Core elements for responding to mental health crises, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009, p,5, 6, 7. Available: https://store.samhsa.gov/shin/content//SMA09-4427/SMA09-4427.pdf
[14] Note: spelling altered to Australian English.

understanding of the crisis means not being limited by services that are compartmentalized according to healthcare specialty. An individual's emergency may reflect the interplay of psychiatric issues with other health factors. And while the individual is experiencing a crisis that tends to be addressed as a clinical phenomenon, there may also be a host of seemingly mundane, real-world concerns that significantly affect an individual's response: the whereabouts of the person's children, the welfare of pets, whether the house is locked, informing someone re absence from work, and so on.

8. **The Person as credible source.** *Assertions or complaints made by individuals who have been diagnosed with a serious mental illness tend to be viewed sceptically by others. Particularly within the charged context of mental health crises, there may be a presumption that statements made by these individuals are manifestations of delusional thinking. Consequently, there is a risk that legitimate complaints relating to such matters as medical illness, pain, abuse or victimization will go unheeded. Even when an individual's assertions are not well grounded in reality and represent obviously delusional thoughts, the "telling of one's story" may represent an important step toward crisis resolution.*

    For these reasons, an appropriate response to an individual in mental health crisis is not dismissive of the person as a credible source of information—factual or emotional—that is important to understanding the person's strengths and needs.

9. **Recovery, resilience and natural supports.** *Certain settings, such as hospital emergency departments, may see individuals only transiently, at a point when they are in acute crisis and in a decidedly high-stress environment. Even when not occurring within hospitals, mental health emergency interventions are often provided in settings that are alien to the individual and the natural supports that may be important parts of his or her daily life. It is important not to lose sight of the fact that an emergency episode may be a temporary relapse and not definitional of the person or that individual's broader life course. An appropriate crisis response contributes to the individual's larger journey toward recovery and resilience and incorporates these values. Accordingly, interventions should preserve dignity, foster a sense of hope, and promote engagement with formal systems and informal resources.*

10. **Prevention.** *An adequate crisis response requires measures that address the person's unmet needs, both through individualised planning and by promoting systemic improvements.*

These Guidelines provide Principles that are key to ensuring that crisis intervention practices embody the 'Essential Values' articulated (pp. 8-12).[15]

MHCC propose that services undertake a TICPOT audit process, and concurrently use this process to implement a set of comprehensive practical guidelines for managing crises such as those referred to above (SAMHSA, 2009). [16] We sincerely believe that this would significantly improve outcomes in acute mental health and intensive care and declared emergency departments in NSW.

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[15] SAMHSA 2009, Practice Guideline: Core elements for responding to mental health crises, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009, pp. 8-12. Available: https://store.samhsa.gov/shin/content//SMA09-4427/SMA09-4427.pdf
[16] Ibid.

Clinical governance and oversight

From a practice standpoint, guidelines may be most effectively enacted when they are embedded in the various quality-control and performance-improvement mechanisms that operate within an organisation. When appropriately conducted, quality control and performance-improvement processes should be data-driven.

Current approaches to crisis services needlessly perpetuate reliance on expensive, late-stage interventions (such as emergency departments) and on settings that have inherent risks of harm for people with mental health needs (for instance, jails and juvenile justice facilities). As implied earlier in this submission (p.11) when we advocated rebalancing investment towards community-based options, resources and personnel that might otherwise be available for more effective, less risky and less expensive interventions are now channelled into these costly and suboptimal settings. *"The factors that sustain late-stage crisis interventions may be linked to funding practices and political considerations, yet in some ways the service system is itself complicit."* Performance-improvement data derived from on-the-ground case experience can paint a compelling story of how *"the right services at the right time"* would look for individuals who are currently at high risk for future crises. These data can also inform discussions on the costs and the benefits of changes in policies governing the provision and funding of services and supports (SAMHSA 2009, Practice Guidelines, pp.14-15).[17]

In short, the approach to responding to crises in public mental health settings must be forward-looking rather than merely reactive, with success seen as the ability of the individual to return to a stable and meaningful life in the community. Its goal must be a reduction in the number of crises among people with *mental illnesses and therefore a reduced need for emergency services."* [18]

In focussing on reduction of crises, the fundamental issue is to recognise the importance of investing in alternative models of care for people requiring complex care in community-based service settings. Characteristically, acute hospital care has remained almost the only place where people with severe mental health difficulties can receive care. Until alternative locations for care and service are established, people requiring mental health care will be scheduled in psychiatric units characterised by their use of seclusion and restraint, not as a measure of last resort but as risk management strategy.[19]

In these inappropriate and under-resourced contexts, seclusion and restraint are accepted practices. Subject to the trauma of seclusion and restraint from the services responsible for caring for them, people with mental health conditions are much less likely to seek support from those that could assist them in the future. The ongoing practice contributes to fear of treatments and may help to explain, in part, the low use of services by those with "mental disorders", a mere 35% according to the last Australian Bureau of Statistics Survey.[20]

In the Australian Government Response to *Contributing lives, thriving communities: Review of Mental Health Programmes and Services*[21] the Government noted the need to improve services and coordination of care for people with severe and complex mental illness.

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[17] SAMHSA 2009, Practice Guideline: Core elements for responding to mental health crises, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, pp.14-15. Available: https://store.samhsa.gov/shin/content//SMA09-4427/SMA09-4427.pdf
[18] Ibid, pp.14-15.
[19] National Mental Health Consumer & Carer Forum 2009, Ending Seclusion and Restraint in Australian Mental Health Services, p.5.
[20] Ibid, p.4.
[21] Commonwealth Government Australia 2015, *Australian Government Response to Contributing lives, thriving communities – Review of Mental Health Programs and Services*, Recommendation 5.8., p.25.

The Review referred to *"that fragmentation of care which is particularly problematic for people with severe and persistent mental illness who often have to navigate a complex system across multiple providers."* It also noted issues of duplication and role confusion for this population group and stressed the importance of a 'medical home' for people with severe and complex mental health conditions. In this context the Review stressed that Primary Health Networks (PHNs) will have a key role in commissioning appropriate services at a local level. This must include facilitating linkages between *"clinical and non-clinical supports, particularly for people with severe and complex mental illness."* [22]

The Review called to:

".........shift the pendulum in Commonwealth expenditure away from acute illness and crisis towards primary prevention, early intervention and a continuous pathway to recovery." [23]

In supporting an integrated model of care MHCC ask the Inquiry to also consider that privacy and confidentiality should not act as barriers to good collaborative care, particularly in the transfer of care and information between services. Sometimes this is used as a way to exclude consumers and carers from gaining information and the National Mental Health Consumer and Carer Forum (NMHCCF) has identified privacy and confidentiality as a matter of great concern for consumers and carers alike. Issues of confidentiality and information sharing are governed by a complex combination of law, policy and professional codes. These rules must account for the balance between ensuring consumers' right to privacy and confidentiality, while taking seriously the needs of carers to be informed and involved – and overall, for both parties to be treated with dignity and respect.[24] The literature (Avon & Wiltshire, 2006) suggests that good information sharing practice requires that consumers, carers, and clinicians work together towards the best interests of the consumer with suggestions that clinicians may benefit from training on how to work in effective partnership with consumers and carers.[25]

Conclusion

MHCC draw the Inquiry's attention to the Australian Government's Response to the *Review of Mental Health Programs and Services* [26] in which they stressed the need to insure effective early intervention across the lifespan by shifting the balance and transitioning services (and therefore funding) from the hospital to community settings. The Review *"found the greatest inefficiencies in the mental health system come from providing acute and crisis response services when prevention and early intervention services would have reduced the need for complex and costly interventions while supporting people to remain in the community."* [27]

Intervening early, and providing the right interventions at the right time, can save enormous costs throughout a person's lifetime. The Review proposed that outlays on hospital funding should reduce over the medium to long term through embedding early intervention in mental health reform, better planning and targeting primary and community care services. [28]

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[22] Commonwealth Government Australia 2015, Australian Government Response to Contributing lives, thriving communities – Review of Mental Health Programs and Services, Recommendation 5.8., p.25.
[23] Ibid, Recommendation 4.4., p.12.
[24] National Mental Health Consumer & Carer Forum 2011, *Privacy, Confidentiality and Information Sharing – Consumers, Carers and Clinicians*, Canberra: NMHCCF, p.16.
[25] Ibid, p.44
[26] Commonwealth Government Australia 2015, Australian Government Response to Contributing lives, thriving communities – Review of Mental Health Programs and Services, p.13.
[27] Ibid, p.44.
[28] Ibid, p.13.

There is now clear evidence from both Australia and overseas about a better and more effective approach to patient care. For example, Like Mind [29] is a service model that provides a place for people to go where they and their families can access both 'clinical' and psychosocial supports, and that reduces the risk of a person requiring care in an acute setting which may lead to greater risk of the use of restrictive practices. Like Mind is a non-hospital environment offering early intervention and holistic care that requires primary health, public and community managed services to work together to provide an integrated model of care.

MHCC express their willingness to be engaged in future consultations concerning this review. For further information concerning this submission please contact Corinne Henderson, Principal Advisor/ Policy & Legislative Reform at corinne@mhcc.org.au

Jenna Bateman
Chief Executive Officer
20 September 2017

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[29] Like Mind website, Available: http://likemind.org.au/about-us/

Appendix 1

Principles of Trauma-Informed Care and Practice [4]

Broadly speaking trauma-informed care and practice principles are:

- based on current literature
- informed by research and evidence of effective practices and philosophies
- led by consumers/survivors
- culturally safe and inclusive

The **eight foundational principles** that represent the core values of trauma-informed care and practice are:[5]

1. **Understanding trauma and its impact -** Understanding traumatic stress, and how it impacts people, and recognising that many challenging behaviours represent adaptive responses to past traumatic experiences

2. **Promoting safety -** Establishing a safe physical, psychological and emotional environment where basic needs are met, safety measures are in place particularly in relation to responding to suicidality, and provider responses are consistent, predictable, and respectful

3. **Ensuring cultural competence -** Understanding how cultural context influences perception of and response to traumatic events and the recovery process; respecting diversity; providing opportunities for consumers to engage in cultural rituals; and using interventions respectful of and specific to cultural backgrounds

4. **Supporting consumer control, choice and autonomy -** Helping consumers regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy; keeping consumers well-informed about all aspects of the system; outlining clear expectations; providing opportunities for consumers to make daily decisions and participate in the creation of personal goals; and maintaining awareness and respect for basic human rights and freedoms

5. **Sharing power and governance -** Promoting democracy and equalisation of power differentials; and sharing power and decision-making across all levels of an organisation, whether related to daily decisions or in the review and creation of policies and procedures

6. **Integrating care -** Maintaining a holistic view of consumers and their recovery process; and facilitating communication within and among service providers and systems

7. **Healing happens in relationships -** Understanding that safe, authentic and positive relationships can aid recovery through restoration of core neural pathways

8. **Recovery is possible -** Understanding that recovery is possible for everyone regardless of how vulnerable they may appear; instilling hope by providing opportunities for consumer and former consumer involvement at all levels of the system; facilitating peer support; focusing on strength and resiliency; and establishing future-oriented goals.

Appendix 2

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http://www.samhsa.gov/sites/default/files/topics/trauma_and_violence/seclusion-restraints-2.pdf

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http://www.samhsa.gov/sites/default/files/topics/trauma_and_violence/seclusion-restraints-1.pdf

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[1] National Association of State Mental Health Program Directors (NASMHPD) 2006, Six Core Strategies for Reducing Seclusion and Restraint Use, Available: http://www.nasmhpd.org

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[3] Ibid.

[4] Fallot, RD & Harris, M 2009, *Creating Cultures of Trauma-Informed Care (CCTIC): A Self- Assessment and Planning Protocol*, Community Connections, Washington, DC. Available from: http://www.healthcare.uiowa.edu/icmh/documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf

[5] These principles were identified and adapted on the basis of knowledge about trauma and its impact, findings of the Co-Occurring Disorders and Violence Project (Moses, DJ, Reed, BG, Mazelis, R & D'Ambrosio, B 2003, *Creating Trauma Services for Women with Co-Occurring Disorders: Experiences from the SAMHSA Women with Alcohol, Drug Abuse, and Mental Health Disorders who have Histories of Violence Study*, Policy Research Associates, Delmar, NY, literature on therapeutic communities); Campling, P 2001,'Therapeutic Communities', *Advances in Psychiatric Treatment*, vol.7, pp.365–372; Fallot, RD & Harris, M 2009, *Creating Cultures of Trauma-Informed Care (CCTIC): A Self- Assessment and Planning Protocol*, Community Connections, Washington, DC. Available from: http://www.healthcare.uiowa.edu/icmh/documents/CCTICSelf-AssessmentandPlanningProtocol0709.pdf
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