

Submission to the Ministry of
Health's *Review of seclusion,
restraint and observation of
consumers with a mental illness in
NSW Health facilities*

September 2017

Background

Our submission is informed by our extensive work in relation to people with disability over the past 15 years, including our consultations with the disability and mental health sectors. Under the *Community Services (Complaints, Reviews and Monitoring) Act 1993*, the responsibilities of our office include a range of functions targeted at improving the delivery of services to people with disability, including:

- receiving and resolving complaints about community services, and assisting people with disability to make complaints
- reviewing the pattern and causes of complaints about community services, and making recommendations to improve how services handle and resolve complaints
- monitoring and reviewing the delivery of community services, and making recommendations for improvement
- inquiring into matters affecting people with disability and community services, and reviewing the situation of people with disability in residential care
- reviewing the causes and patterns of the deaths of people with disability in residential care, and making recommendations to reduce preventable deaths, and
- coordinating the Official Community Visitor scheme.

In November 2012, we tabled a special report to Parliament on our inquiry into the situation of people with disability who were remaining in mental health facilities beyond the point at which they clinically needed to be there: *Denial of rights: the need to improve accommodation and support for people with psychiatric disability*. Key elements of the inquiry included reviewing the files of 95 people in 11 mental health facilities across NSW; and consultation with almost 300 stakeholders, including government and non-government organisations, consumer and carer groups, advocates and peak agencies.

Since 3 December 2014, our office has had responsibility for the Disability Reportable Incidents scheme in NSW, involving the mandatory reporting by disability services of allegations relating to abuse and neglect of people with disability who live in supported group accommodation (under Part 3C of the *Ombudsman Act 1974*).¹

In addition, under the Ombudsman Act, our office has responsibility for handling and resolving complaints about the administrative conduct of NSW Health, including Local Health Districts.

An integrated approach to safeguards

As noted above, we have a suite of functions in relation to people with disability and other vulnerable people accessing or eligible to receive community services. Our integrated functions in handling and investigating complaints; monitoring and reviewing the delivery of services; inquiring into major issues affecting individuals or services; overseeing disability reportable incidents; providing community education; and coordinating the Official Community Visitor scheme, enable us to play a strong and effective role in identifying both unacceptable practices and systems which fail to protect human rights. Importantly, the exercise of our various functions is seen by key advocacy groups as a critical safeguard for people with disability in NSW.

¹ For more information, see: <https://www.ombo.nsw.gov.au/what-we-do/our-work/community-and-disability-services/part-3c-reportable-incidents>.

Nationally, there is significant work underway to develop the NDIS Quality and Safeguarding framework, and to establish the related NDIS Quality and Safeguards Commission. The national framework and the functions of the Commission are intended to provide an integrated approach to safeguards for NDIS participants, including people with psychosocial disability. The strength of the NSW safeguarding system for people with disability is reflected in the fact that the intended national framework replicates many of our existing and integrated functions – including complaints; oversight of reportable incidents (including deaths); oversight of the delivery of services; inquiries and investigations; and work to build capacity and strengthen actions by people with disability (and their supporters), staff, and providers.

In relation to the mental health sector, while we appreciate that there is a range of safeguards, there does not appear to be an integrated approach in this area. For example, we note that, while the NSW Mental Health Commission has a focus on systems and systemic issues, it does not have a complaints function; and depending on the issue, complaints about health services can be made to the Health Care Complaints Commission or our office. By way of further example, we note that, unlike Community Visitors who operate under our office's support and related legislation, the Mental Health Official Visitors sit within NSW Health rather than the Mental Health Commission or other external oversight and review body.

In June 2017, we consulted with people with psychosocial disability to inform our *Rights Project for People with Disability* – a FACS-funded project that is aimed at helping people with disability to understand and exercise their rights; promoting accessible complaint systems and practices; and strengthening systems to prevent, identify, and respond to the abuse and neglect of people with disability. In our consultations, people with psychosocial disability told us of the critical need for an integrated and user-friendly approach to safeguards in the mental health sector, with clear connections between complaints and action to address systems and systemic issues.

Strengthening safeguards associated with Official Visitors

We have a longstanding and positive relationship with the Mental Health Official Visitor program. The information and advice we received from the Official Visitors greatly informed our *Denial of rights* inquiry involving people in mental health facilities. We meet to discuss emerging issues affecting people with mental health needs, and refer relevant matters for the consideration and action of our respective agencies as required. In our view, the Official Visitor program would be significantly strengthened by being situated in an independent oversight body, rather than within NSW Health. It is important that Official Visitors are not only independent, but that they are *perceived* to be independent by consumers, families and others.

We have achieved substantial change and improved outcomes for vulnerable adults under our jurisdiction as a result of the close link between the Official Community Visitor (OCV) scheme and our complaints and broader systemic functions – particularly in relation to matters concerning violence, abuse and neglect. These matters have benefitted from the separate but complementary functions we perform: notably, the ability of Visitors to identify incidents of abuse and neglect and the associated impact on individual residents, and to act to raise and resolve the issues as independent persons; and the powers and ability of our office to progress these matters on an individual and/or systemic basis when escalated by the Visitors or separately identified through our examination of visit reports.²

² For example, we have a standing inquiry under section 11(1)(e) of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* in relation to the abuse and neglect of people with disability. As part of the inquiry, we regularly extract and examine visit reports in which Visitors have raised issues of abuse and neglect with the service provider, and consider what action may be required by our office.

A consistent approach to the regulation of restrictive practices

We support initiatives to increase the external oversight of the use of restraints and restrictive practices, particularly in regard to vulnerable people, and believe that the review provides a valuable opportunity to consider how greater alignment can be achieved in relation to the regulation of restrictive practices across settings. In our recent special report to Parliament on our *Inquiry into behaviour management in schools*,³ we noted that there has been a push to achieve a uniform approach to regulating restrictive practices that applies to a broad range of settings, including disability services, schools, aged care, and mental health.⁴ In relation to people with disability, the development of the NDIS Quality and Safeguarding framework was considered an opportunity to develop a consistent approach across settings; however, the intended behaviour support function of the national Senior Practitioner (under the NDIS Quality and Safeguards Commissioner) only relates to NDIS providers.

While the establishment of a Senior Practitioner within the NDIS Quality and Safeguards Commission⁵ is focused on NDIS providers, there would be merit in considering how the role and the activities associated with the set up of the Senior Practitioner can be leveraged for the benefit of vulnerable consumers more broadly. In this regard, we note that some submissions to the NSW Law Reform Commission's current review of the *Guardianship Act 1987* have called for the establishment of a Senior Practitioner in NSW. The ACT Government is currently holding consultations on the potential establishment of an ACT Office of the Senior Practitioner to reduce and eliminate the use of restrictive practices, including consideration of potential application across service settings.

We recognise that Health policy provides significant guidance in relation to minimising the use of seclusion and restraint, and appreciate that the *Mental Health Act 2007* includes the relevant principle 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'.⁶ However, our work has underscored the need for requirements in relation to the use of restrictive practices, including seclusion and restraint, to have legislative force. We consider that there is not only a need for legislative requirements governing this area, there is also the need to ensure that the legal rights of vulnerable people – including those with disability – are monitored and upheld in practice.

The importance of leadership and culture

Across our functions involving vulnerable people, we have noted and consistently heard that leadership and staff culture makes a critical difference to the prevention of, and response to, incidents; and to the inclusion and support of people with disability. In particular, we have identified that staff culture is a critical factor in whether policy requirements are reflected in practice. This has been the case in our work in relation to vulnerable people in schools, disability services, designated agencies, and health/ mental health services. In relation to the latter, our *Denial of rights* report identified that despite clear discharge planning policy requirements:

³ NSW Ombudsman (August 2017) *NSW Ombudsman Inquiry into behaviour management in schools*, pp26-34.

⁴ For example, in 2014, the Australian Law Reform Commission reported that initiatives at a national level, such as the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* and the development of a national quality and safeguards system for the NDIS, provided an opportunity to gain a uniform approach across settings. Australian Law Reform Commission (Nov 2014), Report 124: *Equality, Capacity and Disability in Commonwealth Laws*.

⁵ For further information on the NDIS Senior Practitioner role, see the NDIS Quality and Safeguarding Framework, https://www.dss.gov.au/sites/default/files/documents/02_2017/ndis_quality_and_safeguarding_framework_final.pdf

⁶ *Mental Health Act 2007*, section 68(f)

- there was poor compliance by staff in mental health facilities with the relevant discharge planning policy, and
- staff attitudes about the welfare and capability of individuals had a direct impact on discharge planning – including the belief that some patients were better supported in hospital than in the community, and a focus on deficits and previous risks.

We note that the NSW Mental Health Commission's submission to the *Inquiry into the Management of Health Care Delivery in NSW* also emphasised the importance of addressing staff culture, observing that:

While policy and practice standards are important in addressing seclusion, restraint and observations, the critical challenge is changing the culture within mental health units... A part of culture change is also about not tolerating unacceptable professional practice.⁷

We support the views of the NSW Mental Health Commission. We also believe that key actions in the disability sector – to roll out a 'zero tolerance' approach to abuse and neglect; to support clients and staff who report unacceptable practice; and to introduce a mandatory scheme for the reporting and independent oversight of serious incidents in disability accommodation services – provide useful guidance for improving staff culture and enhancing safeguards for mental health consumers in relation to seclusion and restraint.

Since the start of the Disability Reportable Incidents scheme on 3 December 2014, we have received nearly 2000 notifications of alleged abuse and neglect of people with disability who live in supported group accommodation.⁸ Allegations against employees comprise approximately half of all notifications. Significant outcomes, actions and improvements arising from work in relation to reportable incidents – in conjunction with our broader functions – include, but are not limited to:

- 23 criminal charges have been laid against employees.
- Management action has been taken by providers in 72% of finalised cases, including 112 employees who have been dismissed or permitted to resign ahead of action being taken against them.⁹
- Actions to empower consumers to report abuse – we have delivered 'Speak Up' training to approximately 1000 people with disability in supported accommodation, staff and families, to support people with disability to speak up about abuse and other issues of concern. The data from the reportable incidents scheme shows that the source of the allegation in almost one-quarter (23%) of the notified matters has been the alleged victim with disability.
- Actions to support staff to report abuse – we have provided guidance and continue to deliver training to direct care staff and managers of disability accommodation services on preventing and responding to serious incidents. We have received an increased number of contacts from staff members raising concerns about the practices of service providers, and about the circumstances of clients (in their service and in the community). The data from the reportable incidents scheme shows that the source of the allegation in over half of all reportable incidents (58%) has been staff.

⁷ NSW Mental Health Commission (July 2017) *Submission to the Inquiry into the Management of Health Care Delivery in NSW*, p5

⁸ Allegations relating to the inappropriate use of restrictive practices are included in the scheme, and are typically reported as either assault or ill-treatment (depending on the alleged conduct).

⁹ Data on the Disability Reportable Incidents scheme, complaints, and reviewable disability deaths is available in the Disability e-News Update newsletter on our website: <https://www.ombo.nsw.gov.au/news-and-publications/publications/newsletters>.

- Aside from disciplinary proceedings, actions in response to the alleged inappropriate use of restrictive practices – reported through the reportable incidents scheme, complaints, and Official Community Visitors, or identified through our reviews of the deaths of people with disability in residential care – have included the engagement of clinical expertise; development and implementation of improved systems for recording and reporting on the authorisation and use of restrictive practices; and the provision of increased supports for individuals.

Empowering consumers

Consistent with information above, it is critical that concerted and ongoing efforts are made to maximise the ability of consumers to be able to speak up about abuse and other unacceptable circumstances in relation to their care – and that their reports and disclosures are heard and acted on.

A key message from our recent consultations with people with psychosocial disability was the need for people with mental illness and psychosocial disability to have a stronger voice in all aspects of their lives, including decision-making. We received a clear message that the stripping away of decision-making powers and being subject to coercive practices is a dehumanising and damaging experience.

We also heard that key factors impeding the rights of people with psychosocial disability include exclusion and restraint; the experience of trauma; and the deprivation of liberty. We were told that it is important for people with psychosocial disability to be valued as individuals in hospital, not just seen as a cluster of symptoms. We heard consistent messages that people carry their hospital experiences with them throughout their lives, including trauma associated with the use of seclusion and restraint.

In our consultations, we were also told about the need for, and importance of, recovery focused care – including access to peer support and advocacy, and a trauma-informed approach.

Meeting the needs of people with disability

Our work has highlighted the need to ensure that people with disability are specifically considered in health policy. In addition to people with psychosocial disability, a high proportion of people with intellectual disability also have mental health concerns. In *Living Well*, the NSW Mental Health Commission reported that an estimated 40% of people with an intellectual disability have experienced a mental disorder of some kind, and noted that health and disability systems do not always have the appropriate skills to address the complexity presented by people with intellectual disability and mental illness.¹⁰

The *Aggression, Seclusion and Restraint in Mental Health Facilities in NSW* policy identifies groups of consumers that ‘may be more vulnerable to physical or psychological harm’ – such as people who are older, identify as Aboriginal and Torres Strait Islander, and/or have a history of trauma – and indicates that it is ‘critical to adopt non-restrictive means of managing disturbed behaviour’ for these individuals whenever possible. People with intellectual disability are not identified as one of the ‘special groups’ in the policy. While we appreciate that people with intellectual disability or other cognitive impairment may be represented in some of the identified groups, they have specific needs that warrant particular consideration. In this regard, and among other things, relevant factors for consideration may include consent; co-morbidities including physical illness; a history of trauma, including trauma associated with the use of restrictive practices; communication

¹⁰ NSW Mental Health Commission (2014) *Living Well: A Strategic Plan for Mental Health in NSW*, p88

impairments (including the impact on the person's ability to indicate pain, and other support needs); and liaison with disability support staff.

There would be strong merit in consulting with acknowledged leaders in this area, including Professor Julian Trollor and Jim Simpson. Professor Trollor is a neuropsychiatrist; holds the inaugural Chair of Intellectual Disability Mental Health at the University of New South Wales (UNSW); and heads the UNSW Department of Developmental Disability Neuropsychiatry within the School of Psychiatry. Jim Simpson is a senior advocate with the NSW Council for Intellectual Disability; a presiding member of the Guardianship Division of NCAT; and a former presiding member of the Mental Health Review Tribunal.

Data

In our most recent report on the reviewable deaths of people with disability in residential care in NSW, we noted that there is no consistent mechanism across NSW health services to identify people with disability in health data.¹¹ We identified that the creation and roll out of a health data identifier(s) for people with disability is critical to assist health staff to identify and best support their needs; enable health services to clearly measure and report on the adequacy of support and key performance indicators related to improving health outcomes; and facilitate data analysis to inform broader service planning. While the *Aggression, Seclusion and Restraint in Mental Health Facilities in NSW* policy refers to collecting and reporting on data relating to seclusion, without a data identifier for disability (particularly intellectual disability), there does not appear to be capacity to identify:

- a) the extent to which people with disability are represented or over-represented in such practices, and
- b) compliance with the policy requirements in relation to people with disability.

Seclusion of other people with mental illness

We appreciate that this review is focused on mental health consumers in NSW Health facilities and services – including patients in the Forensic Hospital. However, it is important to recognise that there are many forensic patients who are detained in prisons. In this regard, we note that the NSW Mental Health Commission has reported that 15% of all forensic patients in NSW are detained in prisons, 'commonly due to a lack of available places in non-custodial settings'.¹²

One of the roles of our office is to visit and handle complaints from people who are detained in correctional centres in NSW. An issue that is often raised with us relates to the seclusion of forensic patients (and other inmates with mental illness) via transfer to an observation cell within a correctional centre when they are at risk of self-harm. These transfers usually occur following the recommendation of a 'Risk Intervention Team', which generally comprises both correctional and Justice Health staff. However, the monitoring of the seclusion is undertaken by correctional staff, not clinical staff. We note that the conditions and safeguards built into the use of seclusion in the Health policy are not available to forensic patients who are unable to be accommodated in a non-custodial setting due to a lack of available places.

¹¹ NSW Ombudsman (June 2015) *Report of Reviewable Deaths in 2012 and 2013, Volume 2: Deaths of people with disability in residential care*, pp66-67, <https://www.ombo.nsw.gov.au/news-and-publications/publications/annual-reports/reviewable-deaths-vol-1/report-of-reviewable-deaths-in-2012-and-2013-volume-2-deaths-of-people-with-disabilities-in-care>

¹² NSW Mental Health Commission (2017) *Towards a just system: mental illness and cognitive impairment in the criminal justice system*, p22

We would be pleased to discuss any aspect of our submission, and to provide further information as needed. Please do not hesitate to contact Carol Berry, Principal Project Officer, on 9286 1086 or cberry@ombo.nsw.gov.au.