

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

Legal Aid NSW submission to
NSW Health

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About Legal Aid NSW

The Legal Aid Commission of New South Wales (**Legal Aid NSW**) is an independent statutory body established under the *Legal Aid Commission Act 1979* (NSW) to provide legal assistance, with a particular focus on the needs of people who are socially and economically disadvantaged.

Legal Aid NSW provides information, community legal education, advice, minor assistance and representation, through a large in-house legal practice and through private practitioners. Legal Aid NSW also funds a number of services provided by non-government organisations, including 32 community legal centres and 29 Women's Domestic Violence Court Advocacy Services.

The Civil Law practice provides legal advice, minor assistance, duty and casework services to people through the Central Sydney office and 13 regional offices. The Mental Health Advocacy Service (MHAS) is a statewide specialist service of Legal Aid NSW. The MHAS advises in all areas of mental health law, including regarding discharge from a mental health facility, applications for, or revocations of, financial management orders, and the legal implications of the *Mental Health Act 2007* (NSW) and the *NSW Trustee and Guardianship Act 2009* (NSW). The MHAS also provides representation before the Mental Health Review Tribunal and the Guardianship

Division of the NSW Civil and Administrative Tribunal.

The Coronial Inquest Unit (**CIU**) is also a statewide specialist service of Legal Aid NSW. The CIU provides free legal advice, assistance and representation to people at coronial inquests where the matter involves some 'public interest'. This has included coronial inquests where a person has died while in a psychiatric hospital or other NSW health facility.

Legal Aid NSW welcomes the opportunity to make a submission to the review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities.

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Introduction

Legal Aid NSW welcomes the opportunity to make a submission to the review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities. Legal Aid NSW does not wish to raise concerns about the existing NSW Health policy directive, *Aggression, Seclusion & Restraint in Mental Health Facilities in NSW*. We support the goal expressed in that directive ‘to reduce and, where possible, eliminate the use of seclusion and restraint in public mental health services’.¹

However, we have some concerns relating to the second term of reference, that is, the extent to which existing policies have been adhered to across NSW Health facilities. We suggest legislative change to ensure: regular review of seclusion; legal representation for involuntary patients subject to seclusion; and that long term seclusion is only used as a last resort.

We also encourage the expert panel conducting the review to consider medical care for patients in seclusion, and the use of seclusion and restraint in hospital emergency departments. We make these comments in light of our role in coronial inquests where these issues were raised, and the rise in psychiatric presentations to emergency departments generally.

Finally, we note that investment in early intervention could contribute to the reduction in the need for seclusion and restraint of consumers with a mental illness in NSW Health facilities.

Seclusion and restraint in the Forensic Hospital

Legal Aid NSW is concerned about the use of seclusion and restraint in mental health facilities, particularly in the Forensic Hospital. We are aware of two female patients in the Forensic Hospital who have been subject to seclusion for two and three years. We are concerned that the NSW Health policy directive on seclusion and restraint is not always complied with, as the following two case studies indicate.

One of our clients, ‘Ann’,² was subject to seclusion and restraint for three years. There was no furniture in her room, only a mattress, so she could either lie down or stand up. She was restrained twice a day when food and medication were brought to her room. NSW Health policy provides that restraint should be a last resort,³ and that restraint and seclusion will not be used ‘as a routine procedure’.⁴ These policies do not appear to have been complied with in Ann’s case.

NSW Health policy also provides that seclusion ‘will end as soon as the consumer has regained behavioural control and the immediate risk of serious harm has passed’.⁵ In Jim’s

¹ NSW Health, *Aggression, Seclusion & Restraint in Mental Health Facilities in NSW* PD2012_035 at [1.1].

² The client’s name has been changed to protect her privacy.

³ NSW Health *Aggression, Seclusion & Restraint in Mental Health Facilities in NSW* PD 2012_035 at 9.

⁴ NSW Health *Aggression, Seclusion & Restraint in Mental Health Facilities in NSW* PD 2012_035 at 13.

⁵ NSW Health *Aggression, Seclusion & Restraint in Mental Health Facilities in NSW* PD 2012_035 at 4.12.

case, outlined below, hospital management did not permit Jim's release from seclusion, even after a psychiatrist had indicated that it was no longer necessary.

Case Study – Jim

Legal Aid NSW assisted Jim, an Aboriginal man from western NSW who spent much of his childhood in institutional care. While detained at the Forensic Hospital, Jim assaulted a number of staff, usually in the period following a seizure. He was placed in seclusion 24 hours a day, seven days a week.

The treating psychiatrist formed the view that seclusion was no longer needed, and that culturally appropriate and trauma-informed care would be effective in managing his risk, and that continued seclusion was causing him serious harm. However, hospital management and others wanted more time to implement changes such as employing security staff.

The Mental Health Review Tribunal heard the matter after Jim had been in seclusion for six weeks. The Tribunal ordered that Jim be removed from seclusion, and that seclusion be given in accordance with the treating psychiatrist's opinion. Jim was allowed out once for a period of 30 minutes, but under what Legal Aid NSW's Mental Health Advocacy Service considered to be degrading circumstances. For instance, Jim was required to lie face down on the floor while holds were placed on his arms before he was allowed out of the room.

Further Tribunal proceedings followed, during which the Tribunal confirmed the order. Jim was removed from seclusion the following day.

In light of the concerns raised above regarding compliance with NSW Health policy on seclusion and restraint, Legal Aid NSW recommends closer Tribunal monitoring of the treatment of people subject to long term seclusion. We suggest that the *Mental Health Act 2007* (NSW) (**Mental Health Act**) should require the Tribunal to review any cases where a person is subject for seclusion for seven continuous days, or for a total of seven days in a fourteen day period. If seclusion becomes long term, the Act should require the Tribunal to review at whatever frequency the Tribunal considers appropriate, but at least every three months.

The Tribunal should consider seclusion in the context of the principles in section 68 of the Mental Health Act, in particular, section 68(a):

people with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given

This principle underlies the statutory test concerning the detention of a person for treatment under sections 12 and 31 of the Mental Health Act, and the imposition of a community treatment order under section 53. In each case, the compulsion cannot be

exerted unless no 'other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available'. Legal Aid NSW considers that the same approach should be taken to seclusion. We therefore recommend amendments to the Mental Health Act to provide that:

- 1) Seclusion should not be used if an authorised medical officer is of the opinion that other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available.
- 2) If the Tribunal considers that other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available, then the Tribunal must order the person be released from seclusion.

People in long term seclusion (for more than seven days) are particularly vulnerable, and should always have the right to legal representation before the Tribunal. Legal Aid NSW therefore recommends that section 154 of the Mental Health Act should be amended to ensure that upon review of an involuntary patient who is subject to seclusion, the patient must be represented by a legal practitioner, unless the patient elects not to have such representation.

We note that if the above recommendations are implemented, it is likely that there would be an increased call upon the Legal Aid NSW MHAS for representation before the MHRT. Additional funding may be required to ensure that solicitors are available.

Acknowledging the use of seclusion rooms

When seclusion and restraint is used, it is important for health staff to acknowledge its use and to comply with relevant policies. Legal Aid NSW represented the Gilligan family in the coronial inquest into the death of Benjamin Gilligan. Mr Gilligan died in 2014 after escaping from Dubbo Base Hospital. The coroner's findings indicate that he was placed 'in a "secure" room at the hospital known as the "Purple Room"'. Evidence given before the inquest was as follows:

Each of the doctors was in agreement that notwithstanding any relevant definitions found in NSW Health Policies they regarded placing Ben in the Purple Room as a form of seclusion. Mr Grose from the Local Health District described the Purple Room as a "safe assessment room" rather than a "seclusion room", but there was no real dispute about what it was used for.⁶

The coroner was satisfied that it was appropriate for Mr Gilligan to be placed in the Purple Room, but called for the Local Health District to 'develop and implement a site-specific

⁶ *Findings in the Inquest into the death of Benjamin Gilligan*, State Coroner's Court, Glebe, 7 July 2017, at 19.

policy relating to the use of the “Purple Room” to give effect to the intent and aims of the existing NSW Health Policy’.⁷

Legal Aid NSW supports this recommendation, and suggests that the review of seclusion, restraint and observation consider whether seclusion rooms are being used in other NSW health facilities without being described as such, and without complying with the relevant policies.

Seclusion and restraint in hospital emergency departments

The Gilligan inquest also raised issues over the appropriate response to patients with acute behavioural disturbances presenting at hospital emergency departments, including the use of seclusion and restraint in those circumstances. One of the expert witnesses, Professor Matthew Large, commented that there is no consensus within accident and emergency specialists and psychiatrists as to the best response to acute behavioural disturbances in this context.⁸ Later, Professor Large also observed that there has been:

... an annual rise in mental health presentations to emergency departments of around 10% per year across the state, and psychiatric presentations are now in many places the single most common form of presentation to an emergency department. I do think that there is a need perhaps for further consideration of our approach to acute behavioural disturbance and when it’s appropriate to almost give a general anaesthetic, when it’s appropriate to sedate the patient, when seclusion is necessary, when restraint is necessary.⁹

Two other expert witnesses in the Gilligan inquest, Dr Giuffrida and Dr Klug, agreed that hospital emergency departments are seeing increased numbers of highly agitated patients, and that further efforts are needed to address the problem.¹⁰

In light of this evidence, the coroner recommended that the Minister for Health ‘give consideration to having his Department convene a state wide forum to discuss best practice management procedures for patients with acute behavioural disturbances presenting to NSW Emergency Departments’.¹¹ A copy of the transcript of the expert evidence was also forwarded to the Minister to facilitate this process.¹²

Legal Aid NSW endorses this recommendation, and also encourages the expert panel to consider this issue in the context of the review of seclusion, restraint and observation of consumers with a mental illness in NSW Health facilities.

⁷ Findings in the Inquest into the death of Benjamin Gilligan, at 23.

⁸ Findings in the Inquest into the death of Benjamin Gilligan, at 43.

⁹ Findings in the Inquest into the death of Benjamin Gilligan, at 62.

¹⁰ Transcript, Inquest into the death of Benjamin Gilligan, 24 May 2017, at 62-63.

¹¹ Findings in the Inquest into the death of Benjamin Gilligan, recommendation 1.

¹² Findings in the Inquest into the death of Benjamin Gilligan, at 21.

Ensuring appropriate medical care to patients in seclusion

Legal Aid NSW represented the family of Mr Dimitrakopoulos, who died in 2006 while in seclusion in a psychiatric unit. The coroner found that while Mr Dimitrakopoulos was admitted as a psychiatric patient, his case quickly became a medical emergency. However the staff of the psychiatric unit did not take the appropriate steps to address the medical emergency, such as calling for a medical assessment, contacting the Medical Registrar or transferring Mr Dimitrakopoulos to an acute medical ward.¹³ Evidence was given that the failure to take appropriate steps may have been the result of 'silos', or difficulties in communications between psychiatric and medical staff.¹⁴

The Coroner referred to the development of the 'Between the Flags' program and the 2010 policy directive *Clinical Emergency Response System (CERS) – Yellow zone Response (Clinical Review) and Red Zone Response (Rapid Response/Medical Emergency Team call)*, both designed to improve the detection and response to a patient who is rapidly deteriorating.

Legal Aid NSW suggests that the review of seclusion, restraint and observation consider whether these procedures have been effective in ensuring that people in seclusion receive appropriate medical care. The death of Miriam Merten in seclusion in the Mental Health Unit of Lismore Base Hospital in 2014 may indicate that there are still problems in this regard. Ms Merten died of head injuries after falling down at least 25 times while in seclusion. The coroner found that there were multiple breaches of the policy regarding seclusion, so that appropriate observations and monitoring of Ms Merten were not carried out.¹⁵

Avoiding seclusion and restraint

Finally, Legal Aid NSW notes that in some of the cases discussed above, earlier intervention could have helped the consumer improve their mental health so as to keep them, and others around them, safe. We note Professor Hickie's comment, that without investment in alternative models of care, particularly community based services, 'people requiring mental health care will be forced to attend psychiatric units characterised by their use of seclusion and restraint, not as a measure of last resort but as the default means of keeping order'.¹⁶

¹³ *Findings in the inquest into the death of Nikos Dimitrakopoulos*, State Coroner's Court, Glebe, 22 December 2010, at 15-16, 19-20.

¹⁴ *Findings in the inquest into the death of Nikos Dimitrakopoulos* at 15.

¹⁵ *Findings in the inquest into the death of Miriam Merten*, Coroner's Court Lismore, 7 September 2016.

¹⁶ National Mental Health Consumer & Carer Forum *Ending Seclusion and Restraint in Australian Mental Health Services* 2009, Foreword, 5.