



Seclusion and Time Out – Dr Rowan Davidson

INFORM

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An important function of my Office is to be responsive to quality of mental health care issues brought to my attention by advocacy agencies. One agency raised the issue of seclusion practices because of the number of complaints they had received from patients.

The *Mental Health Act 1996* (MHA) (s.116) states that seclusion means *sole confinement in a room that it is not within the control of the person confined to leave*.

Seclusion and restraint are safety interventions of last resort and are not treatment interventions. This was confirmed by advice from Legal and Legislative Services stating that seclusion could not be considered a type of Emergency Psychiatric Treatment. **Seclusion and restraint should never be used for the purposes of discipline, coercion, or staff convenience** such as managing inadequate staffing levels.

The use of seclusion and restraint creates significant risks for people with mental illness. These risks include serious injury or death, re-traumatisation of people who have a history of trauma, loss of dignity and other psychological harm. In light of these potential serious consequences, **seclusion and restraint should be used only when there exists an imminent risk of danger to the individual or others and no other safe and effective intervention is possible**.

All mental health services should endeavour to prevent, reduce, and ultimately eliminate the use of seclusion and restraint and to ensure that, **when such interventions are necessary, they are administered in as safe and humane a manner as possible by appropriately trained staff**.

This can best be achieved by:

- Early identification and assessment of individuals who may require these interventions of last resort though this does not suggest that seclusion be listed as a planned treatment on a management plan;

- High quality, active treatment programs conducted by trained and competent staff who effectively employ individualised alternative strategies to prevent and defuse escalating situations;
- Policies and procedures that clearly state that seclusion and restraint will be used only as emergency safety measures;
- Effective quality assurance programs to ensure this goal is met and to provide a methodology for continuous quality improvement.
- Close monitoring of any occasions of use of these interventions and reporting as required by the MHA.

These approaches help to maintain an environment and culture of caring that will minimise the need for the use of seclusion and restraint.

Seclusion versus Time Out: Seclusion may only occur in an authorised facility. 'Time out' where a door is locked preventing a person from leaving is in fact 'seclusion' and all the necessary procedures under the Act are to be complied with.

Placing a person in a room from which they cannot leave in a non-authorized facility may be a breach of section 333 of the Criminal Code. A person may only be secluded in a non-authorized facility if there are justifiable and legal reasons for doing so. 'Time out' as part of a behaviour modification plan needs to ensure that the plan meets legal requirements.

Provision of Basic Needs: Complaints received by the Chief Psychiatrist have included allegations that secluded persons have had their clothing removed, denied access to water and their bedding removed. Section 120(a) states that '*appropriate provision is made for the basic needs of the patient, including bedding, clothing, food, drink and toilet facilities*'.

Only in the most exceptional of cases would it be justifiable not to comply with this requirement.

Providing consumers on Community Treatment Orders with information about the Council of Official Visitors

Under the *Mental Health Act 1996* patients on Community Treatment Orders (CTOs) are considered to be involuntary patients. Involuntary patients have rights as detailed in relevant parts of the Mental Health Act. This includes the right to copies of forms, second opinions if dissatisfied with their treatment and a right to a review by the Mental Health Review Board.

Patients on CTOs are also entitled to contact and receive services from Official Visitors. The Head of the Council of Official Visitors (COV) has noted that although detained involuntary patients are aware of the COV, few patients on CTOs are aware or access the services of the COV.

It is therefore important to inform a patient on a CTO of their rights in relation to contacting the COV. All patients on CTOs are to be provided with the COV brochure outlining their services and providing their contact details.

Research into the experience of Community Mental Health Nurses in Western Australia

The Office of the Chief Psychiatrist in conjunction with the School of Nursing, Curtin University, is conducting research on the experience of Community Mental Health Nurses who are either Authorised Mental Health Practitioners (AMHPs) and/or Case Managers of patients on Community Treatment Orders (CTOs).

The purpose of the research is to explore Community Nurses' experience of using powers under the *Mental Health Act 1996*. This is the first time research of this type is being conducted in WA and should provide significant data on the work experience of Community Nurses and their legislative roles.

The commitment for those nurses who would like to participate is approximately one hour of their time for an interview conducted at a mutually convenient place.

Participants will be Community Mental Health Nurses with at least 6 months experience as an AMHP and/or case manager for a patient on a CTO.

If you would like to participate or to ask further questions about the research please contact Tim Rolfe, Clinical Consultant at the Office of the Chief Psychiatrist either on 9222 4217 (Mobile 0419 921 909) or by e-mail (tim.rolfe@health.wa.gov.au).

Complaint to the Press Council Upheld

On 16 March 2005 *The West Australian* published on their front page a picture of a person who had a mental illness and was the suspect in a serious offence. The article included the use of the man's name and publication of his history of mental illness, but it was the use of the photograph of the person without clothing, which was of greatest concern.

Dr Judyth Watson, Head of the Council of Official Visitors and Dr Rowan Davidson, Chief Psychiatrist, separately complained to the Australian Press Council. The complainants noted that the publication of the photograph demeaned and humiliated the man, violated his privacy and exploited his vulnerability. Dr Watson and Dr Davidson were of the view that by placing gratuitous emphasis on his mental illness, the newspaper reinforced the stigma of such illness.

On 18 March, the newspaper published seven letters from readers responding to the initial report, all of them critical of the newspaper's action in publishing the photo. Along with these letters, the newspaper published a much smaller version of the photo. Other critical letters were published on other days.

The Australian Press Council noted that the publication of the photograph, and the second publication on the letters page two days later, breached the Council's principle on respect for the privacy and sensibilities of individuals, and to this extent the Press Council upheld the complaint.

The West Australian is required to publish that the Press Council upheld the complaint which they did on 10 October 2005.

National Safety Plan

The National Mental Health Working Group established the Safety and Quality in Mental Health Partnership Group in 2003. The Chief Psychiatrist, Dr Davidson represents Western Australia on this group. Since its inception the Partnership Group has developed an action plan for safety in mental health - *The National Safety Priorities in Mental Health: a national plan for reducing harm*. The plan has four main priorities: Reducing suicide and deliberate self-harm in mental health services and related health service settings; Reducing use of, and where possible eliminating, restraint and seclusion; Reduce adverse drug events in mental health services; and Safe transport of people experiencing mental disorders. The full report will be available shortly.

Service Reviews by the Chief Psychiatrist

As described in the Winter 2005 IN-FORM the Chief Psychiatrist (CP) has a responsibility under the *Mental Health Act 1996* to monitor the standards of psychiatric care throughout WA. Monitoring is an examination and assessment of information that is gathered by or reported to the CP that relates in some way to mental health service delivery for the individual, their carers or the community. The Act does not differentiate between government and non-government services (public or private) which effectively means that the CP's monitoring activities include hostel/accommodation and support services, crisis, community mental health and inpatient services, emergency departments and any other service that provides a service to people with a mental illness. The following table represents the number of reviews undertaken in three areas.

	2003-04	2004-05
Monitoring care standards in NGOs	3 monitoring reviews of CP Standards in Licensed Psychiatric Hostels	14 medication standards reviews (stage one) of, Licensed Psychiatric Hostels
Clinical Governance Reviews of Mental Health Services	3 reviews that include:- two reviews of integrated metro mental health services; & one review of a statewide service.	3 reviews that include:- one rural and remote service & one integrated metropolitan mental health service & one private mental health service
Audit of Review Recommendations	One rural and remote integrated mental health service audit	
Targeted/Special Circumstances/ Selected reviews	7 reviews that include:- five cases of deaths in custody & two service provision issues	5 reviews that include:- three psychiatric hostel issues & one related to a CG review & one service issue

These reviews are conducted and coordinated by the OCP and mental health staff are seconded to participate on the review teams. Specialist reviewers are sometimes engaged to conduct certain reviews

Legal Advice on Referrals Under The MHA

The Chief Psychiatrist sought legal advice about current practices, which have evolved due to pressure on beds, around the referral process under the Mental Health Act. For example, referred persons are being diverted to an Emergency Department rather than to an authorised hospital and at times the referral form (Form 1) is being altered by persons other than the referrer to enable that to happen.

Question 1: *Is it possible for the referrer not to indicate where the referral is to be made or for the referral (Form 1) to be altered by another person?*

Answer: Section 33 of the MHA requires a referral under section 29 to specify where the person is to be examined. It cannot be left blank or later altered by another person.

Question 2: *Can the police when authorised to transport change the destination on the Form 3?*

Answer: A transport order does not authorise a police officer to take a person referred anywhere other than the authorised hospital or other place specified in the referral.

Question 3: *Does an examination by a psychiatrist in an unauthorised facility such as an Emergency Department have validity if the place on the referral form is an authorised hospital or other place different from the unauthorised facility?*

Answer: There are no powers under the MHA for a person the subject of a referral to be examined at a hospital or place other than the place specified in the referral.

Policies and practices devised by services are to comply with this legal advice.

Reporting of Alleged Staff Misconduct

In order to allay confusion around the reporting requirement of the *Corruption and Crime Commission (CCC) 2003* in regards to staff misconduct and the reporting requirement to the Chief Psychiatrist in relation to his responsibilities under the *Mental Health Act 1996* the Office of the Chief Psychiatrist sought legal advice.

Legal opinion includes that:

1. In complying with the reporting requirements of the CCC, health services are not restricted from complying with the Operational Circular 1646/03 'Matters to be Reported to the Chief Psychiatrist'.
2. The Chief Psychiatrist is responsible for standards of care provided at the relevant mental health institutions. In light of the purposive approach to deal with misconduct as well as the lack of any explicit restriction on communication of the CCC recommendations there is no reason why such findings could not be communicated to the Chief Psychiatrist where they are relevant to the responsibility of ensuring an adequate standard of care to patients.
3. The CCC (section 7B (3)) is to help public authorities (ie the Chief Psychiatrist) to deal effectively and appropriately with misconduct by increasing their capacity to do so while retaining power itself to investigate cases of misconduct, particularly serious misconduct.
4. The CCC has the power to prevent the Chief Psychiatrist from investigating an incident of alleged misconduct however aside from this the Chief Psychiatrist is not prevented from exercising his powers under the *Mental Health Act 1996* to conduct a concurrent investigation into matters of alleged misconduct.

MEDICATION

PAROXETINE –Warning against use in pregnancy

On the 27 August 2004, the United States Food and Drug Administration (US FDA) and GlaxoSmithKline (GSK) notified healthcare professionals of changes to the Pregnancy/PRECAUTIONS section of the Prescribing Information for Paroxetine Controlled-Release Tablets to describe the results of a GSK retrospective epidemiologic study on birth defects and cardiovascular malformation in infants born to women taking antidepressants during the first trimester of pregnancy.

This study suggested a slight increase in the risk of overall major congenital malformations for Paroxetine as compared to other antidepressants [OR 2.2; 95% confidence interval, 1.34-3.63]. In Australia, Paroxetine is already classified as a Category C medicine in the product information documents for health professionals. This classification is given to medicines that have caused or are suspected of causing harmful effects to the foetus.

While the research results are not final or verified as yet, on 7 September 2005 the TGA and the sponsor of Paroxetine in Australia GSK, strengthened the warnings on product information to advise against use during pregnancy. GlaxoSmithKline have also advised healthcare professionals to carefully weigh the potential risks and benefits of using Paroxetine therapy in women during pregnancy and to discuss these findings as well as treatment alternatives with their patients.

Australia's Chief Medical Officer, has cautioned pregnant women not to suddenly discontinue using the medicine as the withdrawal symptoms could be harmful.

Paroxetine is registered in Australia under the trade names Aropax, Oxetine, Paxtine, Chem mart, GenRx and Terry White Chemists Paroxetine, Paroxetine-RL, Paroxetine-BC, Paroxetine Hexal, Espar, Loxamine, Paroxat CR and Ausrox. More information can be obtained at the GSK Hotline: 1800 010 462. Fact sheets can be found on www.tga.gov.au.

PAROXETINE - Drug interactions, CYP2D6 Metabolism

In August 2005, the United States Food and Drug Administration (US FDA) advised that many drugs, including most drugs effective in the treatment of major depressive disorder (Paroxetine, other SSRIs and many tricyclics), are metabolized by the cytochrome P450 isozyme CYP2D6. Like other agents that are metabolized by CYP2D6, Paroxetine may significantly inhibit the activity of this isozyme. In most patients (>90%), this CYP2D6 isozyme is saturated early during dosing with Paroxetine. Concomitant use of Paroxetine with other drugs metabolized by cytochrome CYP2D6 has not been formally studied but may require lower doses than usually prescribed for either Paroxetine or the other drug.

Therefore, co-administration of Paroxetine with other drugs that are metabolized by this isozyme, including certain drugs effective in the treatment of major depressive disorder (e.g., nortriptyline, amitriptyline, imipramine, desipramine, and fluoxetine), phenothiazines, risperidone, and Type 1C antiarrhythmics (e.g., propafenone, flecainide, and encainide), or that inhibit this enzyme (e.g., quinidine), should be approached with caution.

Due to the risk of serious ventricular arrhythmias and sudden death potentially associated with elevated plasma levels of thioridazine, Paroxetine and thioridazine should not be co-administered.

CLOZAPINE – Elderly Patients

In August 2005, the United States Food and Drug Administration (US FDA) also advised elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Analyses of seventeen placebo controlled trials (modal duration of 10 weeks) in these patients revealed a risk of death in the drug-treated patients of between 1.6 to 1.7 times that seen in placebo-treated patients. Over the course of a typical 10 week controlled trial, the rate of death in drug-treated patients was about 4.5%, compared to a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (e.g., heart failure, sudden death) or infections (e.g., pneumonia) in nature. Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo.

Information on Medication

An advocacy agency raised the issue of what information a patient could reasonably expect to receive about prescribed medication from a Psychiatrist. They advise that patients complain that they are not always afforded the opportunity to be fully informed about the proposed treatment.

The National Mental Health Standards states that – *Consumers and carers should be provided with understandable written and verbal information on the potential benefits, adverse effects, costs and choices with regard to the use of medication.*

Every manufacturer of drugs has a patient information sheet that contains extensive information however this may need to be provided to the patient on intramuscular administration when they do not have access to a package with the information in it. Some patients may find the manufacturer's sheet too complex and simplified information should be prepared and in some cases interpreters may be required.