VICTORIAN ombudsman

Investigation following concerns raised by Community Visitors about a mental health facility

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Letter to the Legislative Council and the Legislative Assembly

To

The Honourable the President of the Legislative Council

and

The Honourable the Speaker of the Legislative Assembly

Pursuant to sections 25 and 25AA of the *Ombudsman Act 1973*, I present to Parliament my report into an *Investigation following concerns raised by Community Visitors about a mental health facility*.

Deborah Glass OBE

Ombudsman

14 October 2014

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Foreword

I am providing this report to Parliament because it raises matters of significant public interest in relation to how some of the most vulnerable people in our society are treated. The issues in this report came to light as a result of the work of Community Visitors – a group of 443 volunteers across Victoria who give their time and commitment to safeguard the interests of people with a mental illness or disability.

The investigation has highlighted several issues that agencies which provide services in this sector must consider if they are to meet their legal obligations under the *Charter of Human Rights and Responsibilities Act 2006* to ensure:

> All persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person.

In October 2013 the Public Advocate tabled the *Community Visitors Annual Report 2012-2013*. The report detailed a number of concerns about the care of patients at an adult acute psychiatric facility. Particularly troubling were allegations of the use of excessive force on patients who were restrained. Community Visitors' concerns were compounded by the agency which runs the facility refusing to allow Community Visitors timely and full access to incident reports, despite the patients having provided consent.

After considering the report, and noting concerns expressed in the Parliament and community, my predecessor commenced an own motion investigation into these concerns.

I have provided the agency with a detailed report regarding the issues identified during the investigation. The agency has taken a cooperative and constructive approach to most of my conclusions and recommendations which has allowed most of the matters specific to this facility to be resolved.

However I was unable to reach firm conclusions regarding the allegations of excessive force contained in the 2012-13 Annual Report. This was largely due to the agency's poor record keeping practices resulting in insufficient information upon which the investigation could proceed. It is frustrating for patients, staff subject to allegations, and Community Visitors for these matters to be left without a definitive outcome.

Good record keeping fosters an appropriate culture of transparency and accountability to ensure that people deprived of their liberty are protected when they cannot protect themselves. It is a means by which the public can be assured that allegations of mistreatment are taken seriously and investigated thoroughly. The paucity of records kept by the agency means I cannot provide the public with that assurance in this instance.

The investigation identified that Community Visitors were being refused access to incident reports to assist them in addressing patients' concerns. The agency cited concerns about breaching staff confidentiality and argued that as incident reports are not part of medical files and are not documents required to be kept under the Act, neither the old nor the new Mental Health legislation permitted the immediate access sought by Community Visitors.

My view, shared by the Department of Health, is that the *Mental Health Act 2014*, which came into force on 1 July 2014, allows Community Visitors access to incident reports. Given the clear intention of the legislation to support the role of Community Visitors, ensure their access to relevant documentation to allow them to perform their statutory functions, and the secrecy obligations by which they are bound, I find the agency's interpretation of the law to be overly narrow.

It is clear that the challenges of access to incident reports were not limited to this facility, and are a continuing problem. In their Annual Report 2013-14, tabled in September 2014, Community Visitors again raise difficulties regarding access to incident reports over the last 12 months, and refer to a general increase in incidents of abuse and assaults across all of the Community Visitor streams including mental health. Community Visitors welcome the new Mental Health Act, which they expect will provide them with access to incident reports.

However, given the importance of this access, and because I have been told by Community Visitors that other agencies in Victoria are taking a similarly narrow view, I am recommending that the Secretary of the Department of Health give directions under the Health Services Act as necessary to clarify and resolve this issue definitively.

I am mindful that there are now new legislative arrangements in place for mental health services, which provide for a stronger focus on patient empowerment. If the legislative intent is reflected in everyday practice, this will lead to greater confidence in the mental health system for patients, their families and carers, and the community in general.

The availability of Community Visitors to respond to the concerns of patients is an asset for the mental health system. I commend them for their diligence and commitment, for which all Victorians should be grateful.

Deborah Glass
Ombudsman

Background

1. Community Visitors are volunteers appointed by the Governor in Council to visit accommodation facilities operating under mental health, disability or supported residential services legislation. This investigation was concerned with services previously provided under the *Mental Health Act 1986*, which was replaced by the *Mental Health Act 2014* on 1 July 2014.
2. Community Visitors are empowered by law to visit mental health facilities at any time, unannounced. They may speak with patients, identify concerns about the care being provided and liaise with staff and management to resolve these matters. An annual report is provided to the Parliament via the responsible Minister regarding the work of Community Visitors.
3. The *Community Visitors Annual Report 2012-2013* raised concerns about the care of mental health patients in a number of mental health facilities in Victoria including an adult acute psychiatric facility.
4. The agency is a major provider of health care, including mental health care, in regional Victoria. It operates a number of psychiatric facilities one of which is the adult acute facility raised in the Community Visitors' report.
5. The Community Visitors' report included concerns that:
    - Patients had complained they suffered injuries as a result of staff using excessive force to restrain them.
    - The agency refused to allow Community Visitors full access to incident reports related to patient injuries, despite written authorisations given to Community Visitors by patients.
6. After considering the report and noting the concern apparent in the Parliament and community, my predecessor commenced an own motion investigation into these issues.

Investigation methodology

7. In investigating this matter, my officers interviewed:
    - staff from the facility and the agency
    - staff from the Office of the Public Advocate (OPA)
    - the Chief Psychiatrist and some of his staff
    - Community Visitors
    - carers of two patients treated at the facility.
8. All individuals attended voluntarily and none chose to be legally represented.
9. My investigators reviewed legislation, policies, procedures and other documentary material including that obtained from:
    - the agency
    - the Office of the Chief Psychiatrist
    - OPA
    - Community Visitors.

The investigation

Community Visitors and access to information

10. The *Mental Health Act 1986* permitted Community Visitors, with the patient's consent, to inspect any document or medical record pertaining to their care. The *Mental Health Act 2014* removed the requirement for patient consent for documents other than clinical records. It should be noted that Community Visitors are subject to strict statutory secrecy provisions and training reinforces their responsibilities.

11. This extensive access to information granted to Community Visitors underscores the important role intended for them by Parliament. They have a significant part to play in scrutinising services provided to a particularly vulnerable group in our community – people receiving inpatient treatment for a mental illness.

Allegations of mistreatment

12. It was therefore appropriate that Community Visitors were concerned about allegations from five patients at the facility that excessive force had been used to restrain them, including:

    - being dragged by the hair
    - sustaining injuries to their shoulders from having their arms and hands held behind their back, and
    - bruising and grazing to their forehead and legs.

13. These allegations were detailed in the *Community Visitors Annual Report 2012-2013* and were among the matters that prompted my predecessor to commence an investigation.

Access to incident reports

14. An impasse had developed between Community Visitors and the agency regarding timely and unfettered access to incident reports. When Community Visitors sought access to the reports in following up the allegations referred to in their Annual Report the agency either did not provide them or did so only after lengthy delays. This was despite the Community Visitors having the patient's consent to access information regarding their care.

15. Community Visitors had multiple grounds for considering themselves entitled to access these reports:

    - Under section 112 (1) (d) of the *Mental Health Act 1986*, a Community Visitor was permitted to inspect 'any documents' relating to any person if they had written consent
    - A protocol between the Office of the Public Advocate and the Department of Human Services[1] that requires agencies to:
        i. give Community Visitors reasonable assistance to perform their functions
        ii. not refuse or fail to give full and true answers to their questions
        iii. not hinder or obstruct them
    - Legal advice provided by OPA that they were entitled to access incident reports.

1 The Department of Health, incorporating the area of Mental Health now has this responsibility.

16. I have also received advice from the Department of Health that:

> Community Visitors have a key role to monitor the adequacy and appropriateness of mental health services. Community Visitors can help people receiving mental health services to resolve issues, seek support and make complaints. For these purposes, Community Visitors can inspect any document relating to a person receiving mental health services at prescribed premises, including incident reports.

17. Community Visitors told my investigators there have been times when they could not establish whether issues raised by patients – such as the allegations detailed above – had been appropriately recorded or investigated. As a result, Community Visitors were not able to reassure patients that their concerns had been taken seriously.

18. For its part, the agency took a narrow view of the provisions of the former *Mental Health Act 1986*. The agency did not consider Community Visitors to be entitled to access incident reports as:

    - Incident reports are not 'documents' under the Act and do not form part of patients' medical files.
    - The agency is not required to keep incident reports under the Mental Health Act and so is not required to provide them to Community Visitors, even with a patient's consent.

19. The agency also held concerns that full disclosure of incident reports would be a breach of staff confidentiality when staff may subsequently be cleared of the allegations.

20. I was concerned at the narrow and overly legalistic approach being taken by the agency. This approach was maintained by the agency following the introduction of the *Mental Health Act 2014* which under section 217 allowed the inspection of 'any document' other than a clinical record.

21. Community Visitors are a fundamental safeguard of the mental health system. In addition to the plain meaning of the words in the new Act, I note that the debates around the *Mental Health Bill 2014* record Parliament's intention that Community Visitors will have access to any documents they need to support their work.

22. The *Community Visitors Annual Report 2013-2014* refers to increasing abuse and violence in mental health facilities, which should be reflected in an increase in incident reporting. The report recommends that the Department of Health publishes numbers of patient and staff assaults.

23. It is apparent from the latest Community Visitors report that access to incident reports continues to be an issue, although the expectation of the report is that this will be resolved by the new Mental Health Act.

Poor documentation of incidents

24. The following is an example of one of the incidents at the facility under investigation, and the evidence available:

> A patient told Community Visitors that on a specific date (more than 12 months before this investigation began), staff injured her shoulder when they held her arms and hands behind her back. Medical notes refer to a physical restraint of her arms; a shoulder x-ray 'possibly attributable' to a restraint; and to the patient's repeated complaints that staff had injured her during the restraint. The patient's mother said that the patient did not have shoulder injuries prior to the restraint. A senior agency officer said the restraint would be 'an unusual and awkward posture to put someone in'.

The Chief Executive Officer of the agency stated that 'the overwhelming balance of probability' suggested the patient dislocated her shoulder prior to admission to the facility because she had had physical altercations with the family who physically contained her and she was restrained by a number of police officers. He said it was noted at the hospital that her left arm was seizing up at times prior to any restraint by agency staff, and staff had also been required to restrain her by her arm to allow her visitors to leave. Details were recorded in the patient's file but there was no incident report detailing the patient's allegations.

25. The investigation was unable to reach any conclusions regarding the allegations of excessive force detailed in the 2012-2013 Community Visitors report. This undesirable outcome leaves the matter unresolved for all parties.

26. The major impediment to my forming any meaningful conclusions, or indeed even being able to conduct useful enquiries, was the agency's poor or delayed record keeping. Only one of the five case studies referred to in the 2012-13 Community Visitors report was the subject of an incident report. The lack of available information simply did not enable detailed evidence to be gathered.

27. Good record keeping practices foster the culture of transparency and accountability that needs to be in place to ensure people deprived of their liberty are protected when they cannot protect themselves. It is a means by which the public can be assured that allegations of mistreatment have been taken seriously and investigated thoroughly. The paucity of records kept by the agency means I cannot provide the public with that assurance in this instance.

28. The investigation also established a general under-reporting of injuries to patients related to restraint by agency staff. Ten patient injuries not recorded in incident reports were identified by my investigators in patient files and a former manager of the facility estimated that approximately 24 such injuries would be caused by restraint every year. The agency could only provide three incident reports regarding injuries related to restraint over a three year period.

Lost opportunities to improve practice

29. The under-reporting of incidents is a lost opportunity to analyse and understand the factors contributing to their occurrence.

30. Agency policy[2] requires that restraint is only to be used where there is risk to any person or to property and all preventative strategies and alternative options have been exhausted or considered. The least restrictive form of restraint must be used. This reflects the *National Safety and Quality Health Service Standards and National Standards for Mental Health Services*, which require the reduction and elimination of restraint.

31. The investigation acknowledges that restraint, by definition, requires the use of force with an inherent risk of injury to both patients and staff. Further, the fact that a restraint has led to an injury does not necessarily mean that excessive force was used.

32. Victoria's Chief Psychiatrist has issued guidelines regarding the use of restraint. The guidelines state that the use of restraint can be reduced by:

    - leadership
    - staff education and training
    - enhancing the physical and therapeutic environment and
    - monitoring and analysing restraint data.

2 Restraint – Mechanical and Physical Policy.

33. The Victorian health incident management system (VHIMS) was introduced by the Department of Health in 2011. Agency policy requires staff to report incidents resulting in harm to a person receiving care and 'near misses' where the potential for serious harm is identified. Staff must therefore create incident reports for restraint injuries to patients and for allegations by patients regarding restraint injuries.

34. Minor incidents[3] are reviewed by the facility's Unit Manager and more serious incidents[4] are forwarded to the agency's Risk Manager and Executive Director, Psychiatric Services.

35. Without satisfactory levels of compliance with reporting protocols, any attempt to undertake the analysis recommended by the Chief Psychiatrist cannot be effective.

36. Staff explained that the lack of incident reporting was due to the complicated, time consuming and frustrating nature of the incident reporting process. A former manager also told my investigators that staff had not been trained to understand which issues needed to be reported on VHIMS.

37. The lost opportunity represented by the lack of reporting and subsequent analysis was demonstrated by the issues my investigation was able to identify concerning the training provided to staff.

38. Senior and experienced staff demonstrated a generally poor knowledge of the agency's restraint policies at interview. Most were also critical of the training provided by the agency stating:

    - it was dated and provided by staff who had not recently worked in wards
    - it was focussed on restraint rather than de-escalation techniques
    - casual staff did not receive the same training as permanent staff
    - staff were trained in 'five point' restraint but there were usually insufficient staff to execute the restraint.

39. These are matters that an effective system for capturing and analysing information regarding incidents should have been able to identify and respond to at a much earlier point. Such a system requires confidence both that staff are complying with reporting protocols and the analysis of the data is sufficiently robust.

Action being taken by the agency

40. The agency has taken a number of steps to resolve the issues identified by my investigation.

41. In response to my request that the agency address the issue of when staff are required to create incident reports regarding patient allegations of excessive use of force or injuries, the agency said:

> A patient reporting an injury or alleging excessive use of force by staff, should be assisted to make a formal complaint, which [*the agency*] would then investigate. If the allegation related to an actual incident that requires management using the Patient/Client Incident and Adverse Event Policy and Procedure, preparation of an incident report and subsequent investigation of that incident, would be part of that response.
>
> [*Agency*] policy already requires our staff to support patients in making a formal complaint under such circumstances, and in the event that a patient declined to make a formal complaint, any actual incident is already required to be reported by our staff. We undertake to remind our staff of their obligations.

3 Incidents including those which have not led to any significant injuries to patients.

4 Incidents including where a patient has sustained more than superficial injuries or has died.

42. The agency has taken steps to improve the training provided to staff regarding the use of restraint. Prior to the investigation training consisted of 45 minutes of online theory and a four hour workshop. The agency now provides staff with a day of face-to-face training including role-playing.

43. The agency has funded a Reducing Restrictive Interventions Project Officer for a two year period which commenced in August 2013. This complements a state-wide Victorian Government initiative which has funded a Reducing Restrictive Interventions Project team to work with selected area mental health services over a 12 month period.

44. The early results of the agency's efforts to reduce the incidents of restrictive practices in its facilities are encouraging. The agency has informed me that its seclusion rate fell in the fourth quarter to a level that is likely to place it in the top 20 per cent of performers in the state for this indicator.

45. These issues are not unique to this agency. The *Community Visitors 2012-2013 Annual Report* referred to 39 such incidents of assaults across the state. During the investigation Community Visitors stated that there have been problems with gaining access to incident reports regarding restraint at other similar facilities.

Treatment plans

46. The *Mental Health Act 1986* required the preparation of a treatment plan for each involuntary patient. The purpose of the plan is to provide patients with an understanding of how their treatment is to be managed, and their recovery goals. It is a document the patient can take away, consider and discuss with carers and staff.

47. The *Mental Health Act 2014* does not require a treatment plan to be prepared however I have been advised by the Department of Health that:

> *The National Mental Health Service Standards 2010* published by the Commonwealth Department of Health 2010, require all mental health services to develop and maintain current individual interdisciplinary treatment, care and recovery plans. They are to be developed in consultation with, and regularly reviewed with the consumer and with the consumer's informed consent, their carer(s) and the treatment, care and recovery plan is available to both of them.
>
> All Victorian Government funded clinical mental health services are required to be accredited against both the *National Standards for Mental Health Services 2010* and the National Safety and Quality Health Service Standards.

48. In 2013 there were 20 complaints to the Community Visitors from patients at the facility about treatment plans being provided either late or not at all. A random file audit of 21 patient files by my investigators found that only half contained treatment plans. In one instance a patient had been discharged after 18 days without a treatment plan having been created.

49. Agency staff stated it was a time-consuming process to prepare treatment plans and explain them to patients. My investigators were also told that medical staff are busy and have already noted the information in the patient's medical file.

50. The agency advised that, although formal treatment plans may not have been created:

> … senior medical staff always have a written plan in each patient's file, as this is a prerequisite for any treatment to begin.

51. The agency has accepted my recommendation that it conduct random audits of treatment plans to ensure they are completed in a timely manner. I am therefore satisfied with the action the agency is taking to resolve the matter.

52. However I am concerned that the reasons given by staff for the failure to prepare treatment plans could be repeated at other mental health facilities.

53. The *Community Visitors Annual Report 2013-2014* refers to a continuing state wide delay in the preparation of and a lack of patient engagement regarding the development of treatment plans.

54. I intend to further examine the issues around treatment plans to ascertain whether they are widespread across the mental health system. If my enquiries suggest there is substance to my concerns I will undertake further investigation.

Recommendations

Recommendation 1

If any mental health facility should refuse to provide incident reports to Community Visitors upon request, I recommend that the Secretary of the Department of Health give directions as necessary to clarify the scope of section 217 of the *Mental Health Act 2014* to resolve this issue definitively.

Department of Health's response:

The Department accepts the recommendation.

Recommendation 2

All mental health facilities should conduct regular random audits of treatment plans to ensure they are completed in a timely manner.

Agency response:

The agency accepts the recommendation.

Department of Health's response:

The Department supports the recommendation.

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