Interdisciplinary collaboration: a guide to success!

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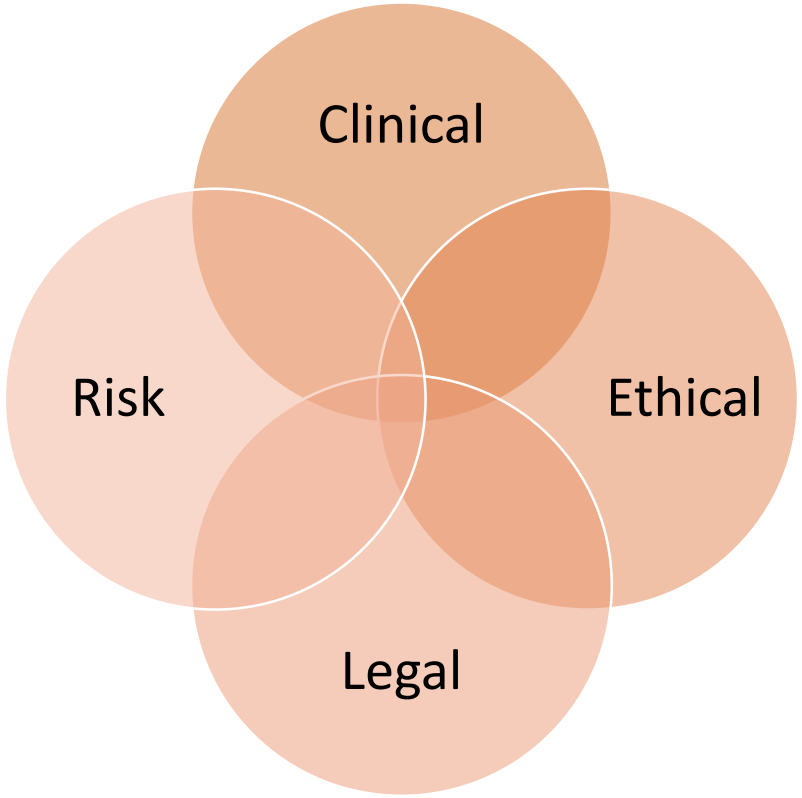
Overview

- Why do we develop guidelines?
- Approach to reducing restrictive practices:
  - Interdisciplinary
  - Patient-centred
  - Recovery focused
  - Trauma informed
- Guidelines content
- Summary



Why develop guidelines?

- Consumer concerns and complaints
- Changes in legislation
- Monitoring, audit and evaluation
- Quality, safety innovation

Electronic communication:

Human Rights

Every patient has the right to enjoy his or her human rights, without discrimination (Charter of Human Rights and Responsibilities Act).

Surveillance:
Health, safety and wellbeing

- Patients
  - The death of Miriam Merten highlights the need for a review of seclusion, restraint and observation (NSW)
- Hospital staff
  - Healthworkers “attacked every hour” (Vic) ~ The Age

Bio-psycho-social-culture-spiritual

Schultz, Walker et al. 2014

Interdisciplinary collaboration

National Practice Standards for Mental Health Workforce 2013

National Standards for Mental Health Services 2010

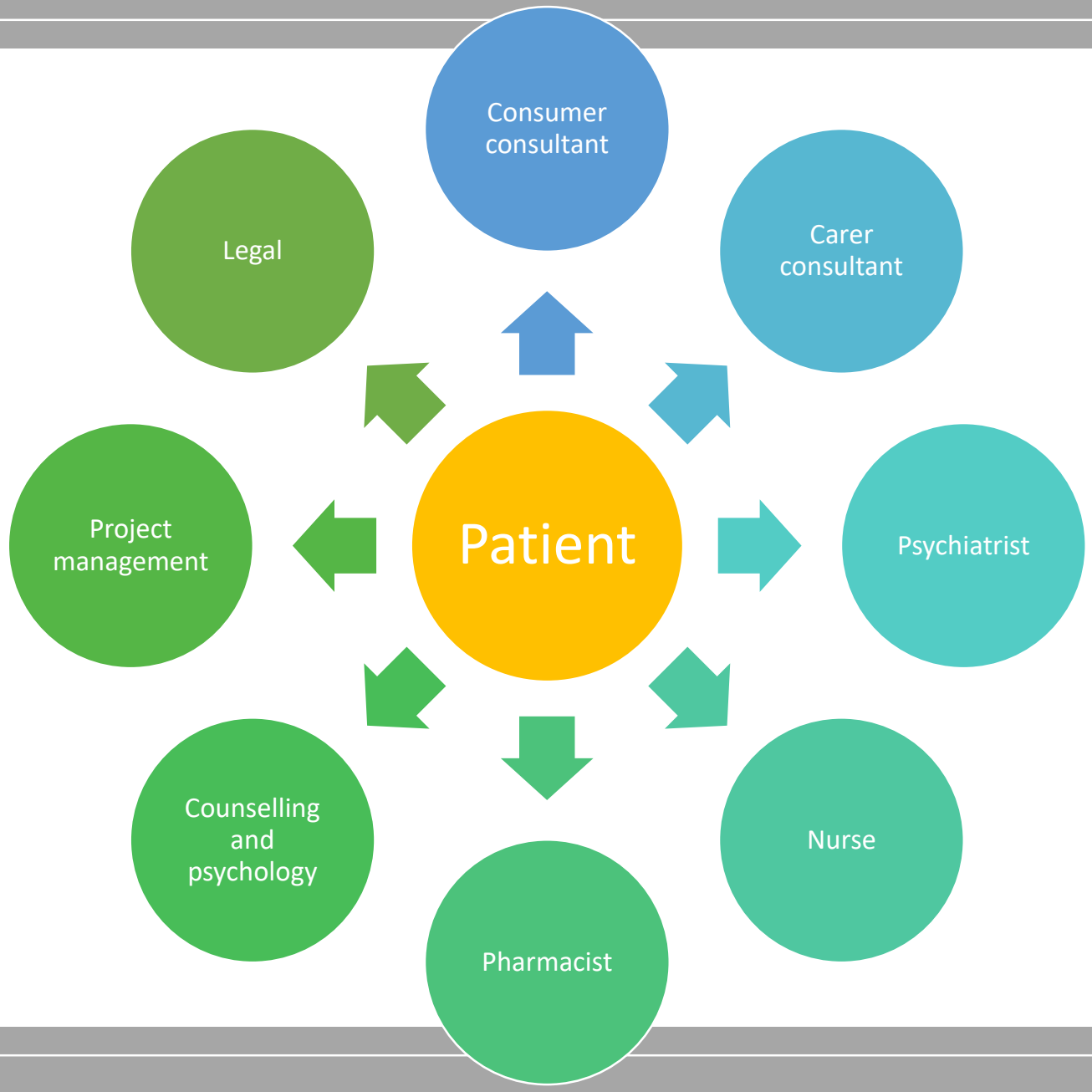
Schultz and Walker, 2014

Overcoming barriers to interdisciplinary collaboration

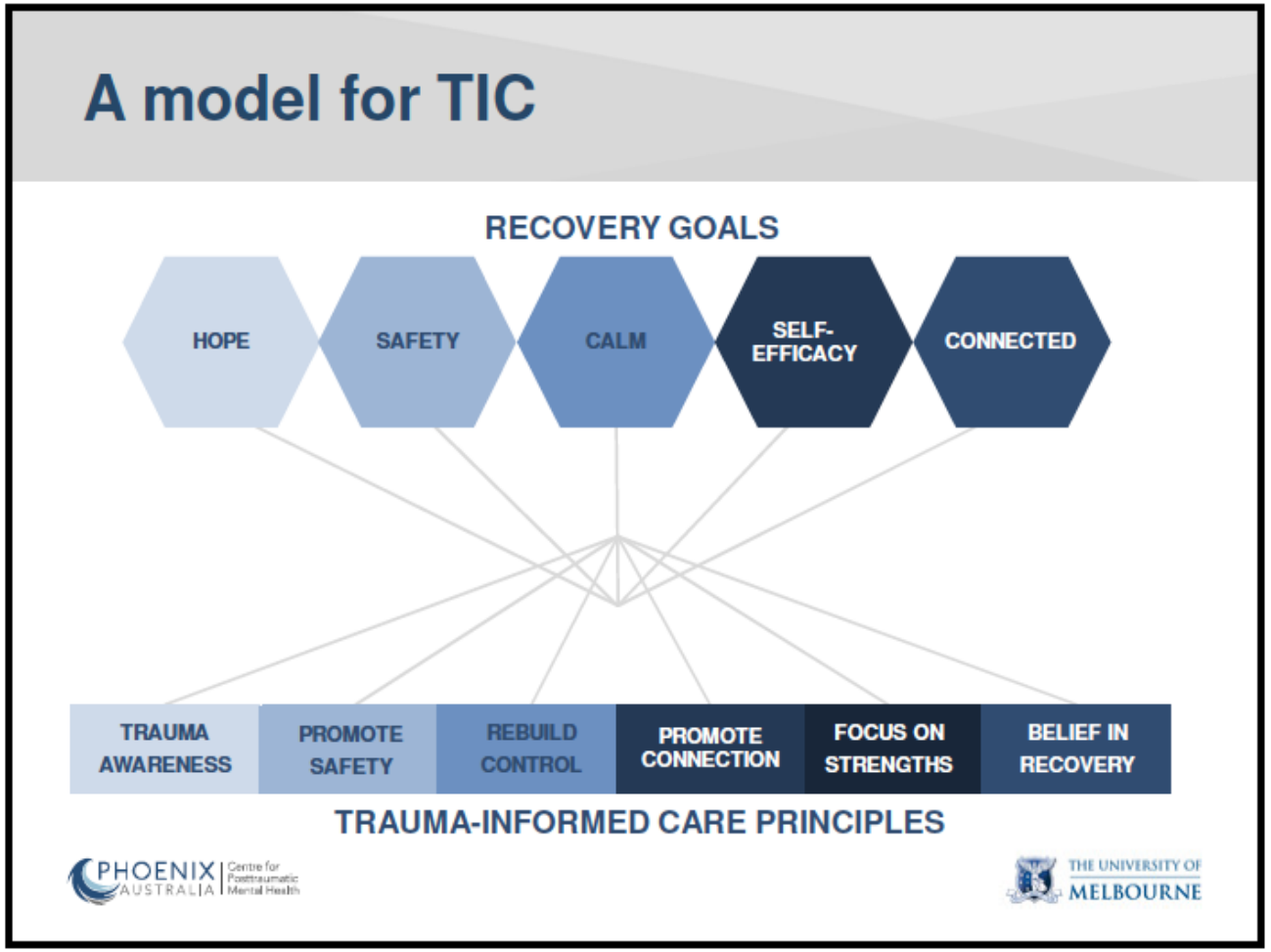
- Lack of hierarchical support within and external to the team
- Inability of the team to share the same vision and goals
- Trivialisation of others' opinions
- Resistance to change and reform
- Lack of access to appropriate resources
- Poor communication within the team
- Lack of personal responsibility and accountability
- Competitiveness within the team
- Individual personalities

Schultz and Walker, 2014

Our interdisciplinary team

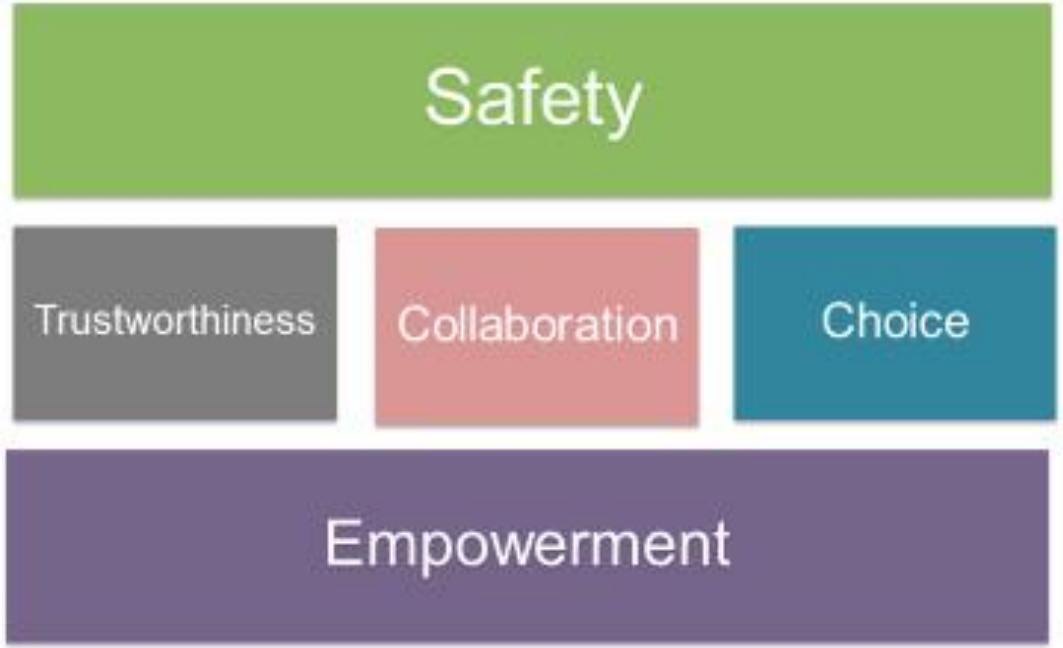


Trauma informed



Principles of trauma-informed practice

blue knot foundation
empowering recovery from childhood trauma



Electronic communication and privacy

Electronic communication and recovery

From the perspective of the individual being treated for mental illness, the use of electronic communication devices can promote recovery, as defined within the *National Standards for Mental Health Services* (2010). In this context recovery means gaining and retaining hope, meaning and purpose in life, understanding one's abilities and disabilities, engaging in an active life, personal autonomy, social identity and maintaining a positive sense of self.

Patients' rights to seek, receive and share information, to own electronic communication devices and to be considered equal are protected by the Charter of Human Rights and Responsibilities Act (see Appendix 1).

Examples of ways that electronic communication devices can promote recovery

- To stay connected to friends, family and other members of a personal support network, including other patients and patient support networks.
- To use features of the device for therapeutic benefit and/or recreation (for example, listening to music, playing games, using self-help apps and watching videos).
- To access legal rights such as legal representation, advocacy, making a complaint, seeking a second opinion, contacting a nominated person or other rights under the Mental Health Act.
- To find out more about mental health problems/diagnoses, recovery, treatments, coping skills, rights information and service standards.
- To seek out support services and options following discharge.
- To address day-to-day needs (paying bills, reading correspondence and communicating with Centrelink or employers).
- To maintain a sense of normalcy/routine (using social media is part of many people's routine) and dignity (almost everyone uses these devices).

Mental Health Act Principles (s. 11)

Persons receiving mental health services should:

- be provided assessment and treatment in the least restrictive way possible
- be involved in all decisions and be supported to make or participate in those decisions, and that their views and preferences should be respected
- be allowed to make decisions that involve a degree of risk
- have their rights, dignity and autonomy respected and promoted
- be provided with services that aim to bring about the best possible therapeutic outcomes and promote recovery and full participation in community life.

Children and young persons receiving mental health services should have their best interests recognised and promoted as a primary consideration.

Patient-centred, recovery-focused decisions about electronic communication devices can be documented in the care plan.

Recovery focused (co-produced with consumer)

Mental Health Act 2014 – Patient's rights
patient-centred, recovery focused
(in collaboration with legal services)

Charter of Human Rights and Responsibilities Act 2001
Mental Health Act 2014
Health Records Act 2001
Surveillance Devices Act 1999

Electronic devices and privacy

Recording a private activity or conversation – for example, about health information – using a 'surveillance device' may contravene the Surveillance Devices Act. Contemporary electronic communication devices typically have the capacity to record audio and visual information and, as such, these devices can be considered 'surveillance devices' under the Act (see Appendix 4).

Unreasonable restrictions

Examples when it would generally not be reasonable to restrict use of electronic communication devices

- A first time breach of the communication policy – especially if there was no prior explanation of the policy and expectations, or no first warning/advice given.
- Taking photos of the facility if other patients and staff are not in the photo (it is reasonable to take photographs of a mental health facility; these are public services and other patients in the hospital can do this).
- Making online purchases (unless there were risks such as accruing significant debt).
- Concern that a patient may use the device for unlawful or harmful reasons but has not actually done so (pre-emptive management of risk).
- Because a patient is making complaints, seeking legal advice, seeking advocacy or expressing anger at the service.
- Because a patient is writing about their experience of being unwell, or of being in hospital, on social media (unless this contravenes the Surveillance Devices Act or Health Records Act). This is an increasingly common and often helpful strategy for people to connect with their community, and to activate their support networks.
- Because a patient is writing about unusual beliefs/delusions on social media (unless this contravenes the Surveillance Devices Act, Health Records Act or otherwise poses a high risk of harm to the person or others).
- Because a patient is researching their treatment, diagnosis, the service or any other issue related to their admission.
- For any punitive reason.

Reasonable restrictions

Restrictions to communication **may** be considered in the following circumstances.

Note: These examples are not exhaustive and every situation needs be tailored to individual circumstances and preferences.

Examples when it may be reasonable to restrict use of electronic communication devices

- Unlawful use of a device (for example, stalking and harassment).
- Breach of another person's privacy, for example:
  - audio or video recording a conversation between a patient and their mental health clinician about their care plan without the express or implied consent of the patient and the clinician and

Examples of unreasonable restrictions (co-produced with consumer)

Examples of reasonable restrictions (co-produced with consumer)

Least restrictive through to most restrictive practices for using electronic communication devices

No restriction

The person can use the electronic communication device at any time, unsupervised.

Least restrictive

- Electronic devices can be used unsupervised and/or in a private space.
- Each patient keeps their own electronic devices in a personal locker. Access to the device is managed by the patient and documented within the care plan.
- Charging points and wireless headphones are available if ligature concerns require removal of cabled items.
- Telephones, computers or tablets with internet access are available for use by any patient within designated areas. Access will depend on local demand.

Restrictive

- Patients don't have access to internet or telephones.
- Patients don't have access to a private area to use devices.
- Patients have to ask staff for access to shared telephones.
- Each patient keeps their own electronic devices, but charging cords are confiscated and provision is not made for other means of charging.
- Headphones are confiscated without a wireless alternative being provided.

Most restrictive

- Patients' devices are confiscated.
- Patients' use of devices is supervised (impinging privacy).

With regard to all the examples provided above, the Mental Health Act provisions need to be met (see Appendix 2).

Least restrictive through to most restrictive practices for using electronic communication devices (co-produced with consumer)

Surveillance and privacy

Patient-centred, recovery orientated

Scope

Common purposes for surveillance within designated mental health services include:

- crime prevention and deterrence
- enhancing the personal safety of patients and staff on mental health units.

CCTV may be useful for monitoring:

- stairways, reception lobbies and service corridors
- external areas such as perimeters, the main entrance and other entry and egress points.

CCTV must not:

- reduce the therapeutic interaction between staff and patients
- be used as an alternative to direct and active clinical observation by staff as this may have a negative impact on therapeutic rapport and infringe on a patient's right to privacy.

□

Difference between surveillance and therapeutic observation

Surveillance to promote safety and security has a different purpose and intention from therapeutic observation and engagement. 'Therapeutic observation' means the purposeful gathering of information from people receiving care to inform clinical decision making and supported decision making by patients. The word *purposeful* implies that observation is undertaken with the intent of obtaining specific information and distinguishes this skill from passive *surveillance*. Therapeutic observation requires engaging with people, including sitting with them, listening to them, understanding their verbal and non-verbal cues, asking pertinent questions and developing an understanding of the most pressing issues in their everyday lives and cannot ever be conducted from behind a barrier or via CCTV.

(*Nursing observation through therapeutic engagement in psychiatric inpatient care*, Department of Health Guideline, 2013)

Surveillance must not be used in areas where patients may reasonably expect privacy

Surveillance **must not** be used in areas where individuals may reasonably expect privacy. This includes:

- bedrooms
- shower areas
- change rooms
- toilets.

Requirement for clinical observation in seclusion (**not** surveillance)

Using remotely managed CCTV in areas such as de-escalation areas including seclusion rooms is not recommended because the images do not accurately provide a status of the patient's physical health and must not replace direct physical supervision by staff.

Staff must be present and directly monitor patients in high-risk areas such as seclusion rooms and high dependency or intensive care units. CCTV can only be used to augment, but never replace, monitoring (such as in blind spots).

When a staff member is not physically present in a locked area, such as in a high dependency or intensive care unit, then this is considered to be seclusion. CCTV is not an alternative to staff presence.

Clinical observation of a person in seclusion requires monitoring of breathing, movement, alertness, responsiveness and levels of agitation. This necessitates engaging with the person directly (**not** via CCTV).

In accordance with s. 112(2) of the Mental Health Act a registered nurse or registered medical practitioner must clinically observe a person in seclusion as often as is appropriate, having regard to the person's condition, but not less frequently than every 15 minutes.

(Chief Psychiatrist Guideline: restrictive interventions in designated mental health services, July 2015)

Summary

- Guidelines are developed to optimize patient care primarily from clinical, ethical, legal and risk perspectives
- Development of guidelines involves interdisciplinary collaboration and co-production
- Approach is patient-centred, evidence based, recovery focused and trauma informed
- Through these principles, patient safety and empowerment are enhanced to reduce the need for restrictive practices