Health
Justice Health & Forensic Mental Health Network

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Hunger Strikes

Policy Number 1.250

Policy Function Continuum of Care

Issue Date 13 April 2017 *(Revised on 9 September 2019 to include Forensic Hospital as a site)*

Summary This policy provides health staff with guidelines for the management of patients on hunger strikes in the custodial and forensic setting.

Responsible Officer ED Clinical Operations

Applicable Sites

- ☐ Administration Centres
- ☐ Community Sites (e.g. Court Liaison Service, Community Integration Team, etc.)
- ☒ Health Centres (Adult Correctional Centres or Police Cells)
- ☒ Health Centres (Juvenile Justice Centres)
- ☒ Long Bay Hospital
- ☒ Forensic Hospital

Previous Issue(s) Policy 1.250 (Dec 2013; Oct 2012)

Change Summary

- Minor grammatical changes
- Minor wording changes
- Added mandatory to notify Clinical Director Primary Care
- Addition of the Forensic Hospital as a site
- Inclusion of processes or procedures for the Forensic Hospital

TRIM Reference POLJH/1250

Authorised by Chief Executive, Justice Health and Forensic Mental Health Network

1. Preface

A hunger strike can be defined as the voluntary abstinence from food and/or fluid. The objective of this policy is to provide health staff with guidelines for the management of patients on hunger strikes and to minimise the risk of a hunger strike to the patient's health.

Note: this policy includes all Long Bay Hospital (LBH) patients including the Mental Health Unit and patients in the Forensic Hospital (FH). This policy operates with some modifications for the FH, noting that the FH is a high security psychiatric hospital with acute and rehabilitation wards. Any references to CSNSW do not apply to the FH.

2. Policy Content

The following positions must be advised of patients undertaking a hunger strike:

- Network Director of Nursing & Midwifery Services (NDNMS) for adolescent and adult patients on a hunger strike
- Service Director Custodial Mental Health (SDCMH) for mental health patients on a hunger strike in custodial settings
- Service Director Long Bay Hospital (SDLBH) for patients in LBH on a hunger strike
- Director of Nursing and Services FH (DNS) and Deputy Director of Nursing (DDON) or FH After Hours Nurse Manager (FHAHNM) for FH patients on hunger strike
- In absence of the above positions, the Executive Director Clinical Operations must be notified
- The appropriate Clinical Director must also be advised of a patient on a hunger strike.

Clear reporting of the patient's refusal of food and/or fluid is required as the patient may elect to refuse food but not fluid, or take small amounts of fluid with medications. The refusal of fluid input could pose a significant risk to the patient's physiological well-being in a shorter timeframe than the refusal of food.

Details concerning the patient's hunger strike must be recorded in the patient's health record and if known the entry should include the reason for the hunger strike and what has been done, or can be done, to prevent it continuing.

2.1 Mandatory Requirements

The following process must be implemented for patients known to be on a hunger strike in the ambulatory setting:

1. The relevant Nurse Manager must be notified by the Nursing Unit Manager (NUM)/nurse in charge of the patient on a hunger strike.
2. The NUM/nurse in charge must email the Nurse Manager by 14:00 hours daily a copy of the patient's Standard Adult General Observation (SAGO) Chart (or Standard Paediatric Observation Chart (SPOC) for young people), Standard Maternity Observation Chart (SMOC) if the patient is pregnant, Daily Fluid Balance Chart and relevant section of the patient's progress notes (or email to the After Hours Nurse Manager (AHNM) should the patient's condition deteriorate after business hours). Should the patient's observations deteriorate, staff must observe the SAGO protocols ie detecting deterioration,

evaluating the situation, implementing simple treatments, escalating care and calling for help. Note that recording food and/or fluid input/output also involves asking a patient how much they are drinking ie 2 cups of coffee, cup of tea, approx. 3 cups of water and where possible measuring their urinary output. If the patient refuses food and/or fluid this must also be recorded in the patient's health record.

3. The Nurse Manager must notify Clinical Director Primary Care (CDPC).
4. The Nurse Manager must notify their Service Director/NDNMS and provide daily updates.
5. The reason for the hunger strike should be obtained if the patient is prepared to disclose this information.
6. When a patient commences a hunger strike a Joint Case Management Plan between Corrective Services NSW (CSNSW)/Juvenile Justice NSW (JJNSW) and Justice Health & Forensic Mental Health Network (JH&FMHN) must be developed. Joint Case Management meetings must occur, particularly for repeat hunger strikers or patients who hunger strike for prolonged periods.
7. Counselling and other measures consistent with CSNSW hunger strike policies must occur to resolve the hunger strike.
8. All patients commencing a hunger strike must be placed on the Mental Health Waiting List Priority 1 for assessment.
9. Patients will not be admitted to hospital unless physical or mental health intervention is required due to deterioration in the patient's physical or mental health status. Decisions regarding hospital admission must be made in consultation with the NUM/nurse in charge/AHNM and the onsite Medical Officer/ROAMS Medical Officer and CDPC.
10. Regular medication must continue to be administered if the patient consents unless contraindicated. The treating or on-call Medical Officer and appropriate Clinical Director and NDNMS/Service Director must be notified if the patient refuses to take essential medication.
11. For patients who have been assessed as lacking decision making capacity, the treating Medical Officer will consult with the Clinical Director and consider involvement of the Guardianship Tribunal Board.
12. A patient's refusal for medical evaluation and treatment must be documented in the patient's health record, including a record of the patient's refusal. This includes patients refusing to take regular medications.
13. Patients requiring insulin or oral hypoglycaemic medication will routinely require review by a Medical Officer as the dosage/regimen may need to be modified. Depending on the frequency of the facility's Medical Officer clinics this may require the patient to be transferred to a suitable location.
14. Food and fluids must always be available and accessible and this must be communicated to CSNSW and JJNSW.
15. Only upon the advice of the appropriate Clinical Director should the monitoring of a hunger strike patient cease. Frontline staff must not cease monitoring once a patient commences eating and/or drinking as a period of 24 hours established food and fluid input must be in place before monitoring is ceased.

The following process must be implemented for patients known to be on a hunger strike in the Long Bay Hospital:

1. The Operations Manager must be informed by the NUM/nurse in charge who will inform the SDLBH.
2. A fluid balance chart must be commenced.
3. The reason for the hunger strike should be obtained if the patient is prepared to disclose this information and recorded in the patient's medical record.
4. For patients who do not have a joint management plan with CSNSW, a plan must be implemented.
5. Counselling and other measures consistent with CSNSW hunger strike policies must occur to resolve the hunger strike.
6. Food and fluids must always be available and accessible.
7. Patients commencing a hunger strike outside of the Mental Health Unit (MHU) must be referred to the Mental Health team.
8. Patients in the MHU must be reviewed by a treating Medical Officer if the patient is refusing to take routine medications such as Insulin.
9. Staff are to update and document in the patient's health record any changes as these occur.
10. It is the responsibility of the Clinical Director to decide when the monitoring of the patient ceases.
11. It is the responsibility of the treating Psychiatric team to inform the Statewide Clinical Director Forensic Mental Health.

The following process must be implemented for patients known to be on a hunger strike in The Forensic Hospital:

1. The AHNM or DDON and treating psychiatrist/registrar must be informed by the NUM/nurse in charge who will inform the DNS.
2. A fluid balance chart must be commenced.
3. The reason for the hunger strike should be obtained if the patient is prepared to disclose this information and recorded in the patient's medical record.
4. Food and fluids must always be available and accessible.
5. Patients must be reviewed by a psychiatry registrar if the patient is refusing to take routine medications such as Insulin, in addition to regular medical reviews.
6. Staff are to update and document in the patient's health record any changes as these occur.
7. It is the responsibility of the treating psychiatrist to decide when the monitoring of the patient ceases.
8. It is the responsibility of the treating Psychiatric team to inform the Clinical Director who will inform the Co- Director Forensic Mental Health (Clinical).

2.2 Implementation - Roles & Responsibilities

Network Director of Nursing & Midwifery Services (NDNMS)

- Is responsible for reviewing documentation of all adolescent and adult patients on a hunger strike in the ambulatory setting.
- Must communicate with the SDCMH, CDPC and Statewide Clinical Director Forensic Mental Health regarding mental health patients undertaking hunger strikes.
- Is responsible (where appropriate) for providing progress reports on adolescent patients to JJNSW.

Service Director Long Bay Hospital (SDLBH)

- Is responsible for reviewing documentation of all patients on a hunger strike in the Long Bay Hospital.
- Is responsible (where appropriate) for providing progress reports on LBH patients to the Executive Director Clinical Operations.

Clinical Director FH & LBH

- Is responsible (where appropriate) to inform and provide progress reports to the Co-Director Forensic Mental Health (clinical)

Director of Nursing and Services Forensic Hospital (DNS FH)

- Is responsible (where appropriate) for providing progress reports on FH patients to the Executive Director Clinical Operations.

Deputy Director of Nursing Forensic Hospital

- Is responsible for reviewing all documentation of all Forensic Hospital patients on a hunger strike
- Is responsible for providing progress reports to the Director of Nursing and Services FH

Clinical Director Primary Care (CDPC)

- Is responsible to provide consultation where a patient on a hunger strike may require hospital admission.
- Is responsible for deciding when to cease monitoring a patient on a hunger strike.

Nurse Manager

- Is responsible for daily updating the NDNMS/Service Director/DNS FH and Clinical Director on each patient's progress.
- The Nurse Manager will provide information on the patient's progress as requested, and at the weekly clinical meetings where applicable.
- Is responsible for advising NUM/nurse in charge regarding the cessation of hunger strike monitoring following advice from the appropriate NDNMS/Service Director/DNS FH.

All Staff

- The NUM/nurse in charge to notify the appropriate Nurse Manager of all patients on a hunger strike. Details must be recorded in the patient's health record and if known, detailing the reason for the hunger strike and what has been done or can be done to stop it.
- The NUM/nurse in charge is responsible for emailing a copy of the patient's SAGO Chart or SPOC, SMOC if the patient is pregnant, Daily Fluid Balance Chart and relevant section of the patient's

progress notes to the Nurse Manager (or to the AHNM should the patient's condition deteriorate after business hours) daily by 14:00 hours. This is not required for FH patients.

- The Nurse Manager should notify the NDNMS/Service Director/DDON to provide daily updates.
- If the patient agrees, the NUM/nurse in charge will ensure that the patients' baseline observations are recorded on a daily basis and electrolytes measured third daily if the patient's fluid input is nil. If the fluid input is nil this must be recorded and the NUM/nurse in charge must discuss this with the Medical Officer.
- The NUM/nurse in charge must facilitate counselling and other measures consistent with CSNSW hunger strike policies to resolve the hunger strike.

3. Procedure Content

3.1 Notification and Ongoing Management

When JH&FMHN staff are notified of a patient's intent to undertake a hunger strike, the patient must be assessed in the Health Centre/Facility if possible.

Any volume of food and/or fluid taken during the patient's hunger strike must be documented on a *Daily Fluid Balance* form (SMR120.001) and in the patient's health record.

If the patient agrees, the following observations should occur on a daily basis:

- physical general wellbeing assessment
- mini mental health examination
- baseline observations
    - Blood Pressure (BP)
    - Heart Rate
    - Temperature
    - Respiratory Rate
    - Blood Glucose Level (BGL)
    - Weight
- Urinalysis
    - Specific gravity
    - pH
    - Ketones.

In addition, if the patient agrees, electrolytes must be rechecked third daily if the patient's fluid input is nil and includes:

- Venepuncture
    - Urea, Electrolytes, Creatinine (UEC) include magnesium (Mg), Phosphate (PO4) & Calcium(Ca)
- Weekly Full Blood Count (FBC).

Normal and abnormal findings must be documented and any abnormality must be discussed with the treating or ROAMS Medical Officer immediately. If the patient does not agree to have vital signs monitored, this must be clearly recorded on the SAGO Chart/SPOC, SMOC if the patient is pregnant and in the patient's health record.

For Aboriginal patients, involvement of an Aboriginal health worker must be arranged by local staff or from the Aboriginal Community Controlled Health Services if available.

For other cultural groups, specific cultural advice should be sought from an appropriate person of that culture to fully understand the reason for the hunger strike and negotiate a solution. It is important to ensure confidentiality and respect.

Patients on hunger strikes will continue to have access to standard CSNSW/JJNSW services and programs. However, it is CSNSW/JJNSW policy that no negotiations with the patient regarding correctional/detention centre placement or regime will be undertaken whilst the patient's hunger strike continues. A Joint Case Management Plan of the patient must occur to ensure the patient is safely monitored and efforts are made to encourage the patient to cease the hunger strike. The NUM/nurse in charge must liaise with CSNSW/JJNSW as appropriate and develop a Joint Case Management Plan for patients who continue to hunger strike intermittently on an on-going basis. Referral to the CSNSW Behavioural Unit should be considered for adult patients and referral to a JJNSW Psychologist for an adolescent patient.

3.2 Mental Health Referral/Management

Hunger strikes occur for a variety of reasons. While hunger striking may be used as a method of exercising control over situations and/or others, it could also indicate possible mental illness or a means of self-harm in a patient. For this reason a referral to the mental health service, must be made for all patients commencing a hunger strike. In facilities where there is no mental health service the Clinical Director will decide if the patient requires transfer to a Health Centre/Facility with mental health services. The decision to transfer will always be clinically indicated (and not as a result of the patient's reason for commencing a hunger strike). The decision to admit the patient to a mental health facility may be made by the treating or on-call Psychiatrist, who will initiate the appropriate transfer arrangements, which may include scheduling the patient under the *Mental Health Act 2007*. Patients with the intent of self-harm/suicide through hunger striking must be placed on a mandatory notification and self harm incident logged on the Incident Information Management System (IIMS). Patients in the Forensic Hospital will be managed on site unless there is a physical health deterioration, in which case they will be transferred to POWH for treatment.

3.3 Medical Management

JH&FMHN has a duty of care to its patients; however JH&FMHN staff will not routinely admit the patient to hospital, either within or outside the correctional/detention system unless medical or psychiatric intervention is necessary. The patient must be informed of this at the commencement of the hunger strike and reminded when necessary. Patients deemed mentally competent must have their right to undertake a hunger strike respected. Medical management should then focus on counselling and ongoing support. Patients on a hunger strike must be reviewed by a Medical Officer weekly (or third daily if the patient is also refusing fluids). The Clinical Director must be informed of progress. A Joint Case Management conference between CSNSW/JJNSW and JH&FMHN must be held weekly to determine ongoing care. If it becomes necessary to admit the patient to either the Mental Health Unit (MHU) or the Medical Subacute Unit (MSU) at Long Bay Hospital, the staff of MHU/MSU must consult with the CDPC and/or Clinical Director Custodial Mental Health for adults and maintain local protocols consistent with this policy.

3.4 Re-establishing food/fluids and Refeeding Syndrome

The re-establishment of food/fluids should not be forced. Mentally competent patients have the right to refuse food and/or fluid and the law recognises this. Staff must be mindful of this and respect the patient's decision.

The consideration of involuntarily refeeding a patient is a serious matter and requires consultation with the CDPC and/or Clinical Director Custodial Mental Health for adults, and the Clinical Director Adolescent Mental Health and Clinical Director Adolescent Health for young people, as well as the Chief Executive prior to this being considered. The rights of the patient and their health status must always be carefully considered. Reference should be made to the JH&FMHN policy 1.085 *Consent to Medical Treatment – Patient Information* including Section 3.11 regarding compulsory medical treatment if applicable.

Food and fluid must always be available for the duration of the hunger strike even if it is not requested. This becomes more important if physical symptoms exist.

Patients who have been on a hunger strike for seven days or longer must be reviewed by a Medical Officer prior to commencing refeeding as these patients are at risk of developing refeeding syndrome. Too rapid refeeding, particularly with carbohydrate may precipitate a number of metabolic and pathophysiological complications, which may adversely affect the cardiac, respiratory, haematological, hepatic and neuromuscular systems leading to clinical complications and even death (Stanga, Z 2008, p. 687). If a Medical Officer is not on site, the NUM/nurse in charge must telephone the ROAMS Medical Officer for a treatment management plan for the patient.

Severely malnourished patients are at particular risk of developing the refeeding syndrome, whose features include:

- Salt and water retention leading to oedema and heart failure, which may be exacerbated by cardiac atrophy
- Hypokalaemia due to rapid cellular uptake of potassium as glucose and amino acids are taken up during cellular synthesis of glycogen and protein
- Hypophosphataemia due to increased phosphorylation of glucose
- Rapid depletion of thiamine, a cofactor in glycolysis, leading to Wernicke's encephalopathy and/or cardiomyopathy (Thiamine is required for carbohydrate metabolism and without it the re-introduction of food can cause an acute thiamine deficiency and result in Wernicke's encephalopathy with permanent neurological damage)
- Hypomagnesaemia due to cellular uptake of this mineral (Stanga, Z 2008, p. 688).

Malnourished patients at increased risk of developing the refeeding syndrome include chronic alcoholics, patients with cancer and with chronic infectious diseases (ie HIV, tuberculosis), diabetics (Stanga, Z 2008, p. 688) and patients on psychotropics.

4. Definitions

Must

Indicates a mandatory action to be complied with.

Should

Indicates a recommended action to be complied with unless there are sound reasons for taking a different course of action.

5. Legislation and Related Documents

Legislation	*Crimes (Administration of Sentences) Act 1999* *Mental Health Act 2007*
NSW Ministry of Health Polices and Forms	PD2013_049 *Recognition and Management of Patients who are Clinically Deteriorating* SMR110010 *Standard Adult General Observation (SAGO) Chart* SMR110019 *Standard Paediatric Observation Chart (SPOC)* SMR110.013 *Standard Maternity Observation Chart (SMOC)*
CSNSW Policy	Sec 7.8 *Inmates who go on a Hunger Strike or Refuse to Eat V1.3 November 2015*
External Resources	Brockman, B. *Food refusal in prisoners: a communication or a method of self-killing? The role of the psychiatrist and resulting ethical challenges* (*Accessed 7 Nov 2016)* Journal of Medical Ethics (1999) 25: 451 – 456 *Dual Loyalty & Human Rights in Health Professional Practice; Proposed Guidelines & Institutional Mechanisms*. *(Accessed 7 Nov 2016)* A Collaborative Initiative of Physicians for Human Rights and the School of Public Health and Primary Health Care University of Cape Town, Health Sciences Faculty – 2002 Printed in United States of America Library of Congress Control Number: 2003101403 Stanga, Z et al 2008, *Nutrition in clinical practice – the refeeding syndrome: illustrative cases and guidelines for prevention and treatment*. *(Accessed 7 Nov 2016)* Journal of Clinical Nutrition, vol. 62, pp. 687-694 Brockman, B. *The implications of starvation induced psychological changes for the ethical treatment of hunger strikers* (*Accessed 7 Nov 2016)* Journal of Medical Ethics (2003) 29: 243 – 247 *World Medical Association: Declaration of Malta on Hunger Strikes* Adopted by the 43rd World Medical Assembly, St Julians, Malta, November 1991 and editorially revised by the 44th World Medical Assembly Marbella Spain, September 1992 and revised by the 57th WMA General Assembly, Pilanesberg, South Africa, October 2006. (*Accessed 7 Nov 2016)*

JH&FMHN Policies and Procedures	1.322 *Recognition and Management of Patients who are Clinically Deteriorating* 1.319 *Patient Observation – Forensic Hospital & Long Bay Hospital Mental Health Unit* 1.085 *Consent to Medical Treatment – Patient Information*

Appendix 1 (This flowchart is not applicable to the FH patients)