

Restrictive interventions in designated mental health services

Chief Psychiatrist's guideline

Introduction

Achieving the best health and wellbeing for all Victorians is a key priority for the Victorian Government. In the Victorian public mental health system, this will be achieved through recovery-oriented practice that minimises the use and duration of compulsory treatment; safeguards the rights and dignity of people with a mental illness; and enhances oversight while encouraging innovation and service improvement.

Consistent with these objectives, the Department of Health, the Chief Psychiatrist and mental health services share a commitment to reducing and where possible eliminating restrictive interventions in mental health services. The aim is to achieve a safe environment through a systematic approach that involves consumers, carers, the mental health workforce and mental health management.

Restrictive interventions are not therapeutic. They are intrusive practices used as a last resort to prevent serious and imminent harm to a consumer or another person. In Victoria, the Department of Health, the Chief Psychiatrist and public mental health services have undertaken a number of activities to promote the reduction of restrictive interventions. Restrictive interventions should only be used after all possible preventative practices have been tried or considered and have been found to be unsuitable. The use of restrictive interventions has been linked to re-traumatisation of past experiences, serious injuries and even death. When used, restrictive intervention needs to be approached by a registered nurse or registered medical practitioner in a way that maximises the physical and psychological well-being of all involved, given the risks involved.

Reducing restrictive interventions is underpinned by the following principles (Department of Health, ***Providing a safe environment for all: Framework for reducing restrictive interventions, 2013*** (<http://docs.health.vic.gov.au/docs/doc/Providing-a-safe-environment-for-all:-Framework-for-reducing-restrictive-interventions>))

- All key stakeholders (consumers, carers, mental health service staff, management and the government) have a role in the design and implementation of safe environments.
- Consumers, carers and mental health staff are treated with respect and dignity; their rights and responsibilities are central to promoting safety.
- The service environment is organised to ensure the safety and wellbeing of consumers, carers, and mental health staff.
- Difficult and challenging behaviour is managed in ways that show decency, humanity and respect for individual rights, while effectively managing risk.
- Restrictive interventions are used as a last resort and for the briefest duration after all other less restrictive options reasonably available have been tried or considered and found to be unsuitable in the circumstances.
- Programs to reduce restrictive interventions require effective governance and ongoing monitoring of local strategies and initiatives to ensure effective implementation.
- Recovery-oriented practice, trauma-informed care, supported decision making and family/carer inclusive practice inform workforce practices and are necessary to create positive clinical cultures and to prevent cultures that are coercive or create conflict.

Using this guideline

The use of restrictive interventions must follow both the legal requirements of the Mental Health Act 2014 (the Act) and best practice requirements as indicated in the evidence based literature. In this guideline, these requirements are arranged into three parts surrounding the use of a restrictive intervention (leading up to the use of a restrictive intervention; during the actual use; and following the use of the intervention).

All Victorian designated mental health services are required to have in place local policies, procedures and clinical practices that reduce, and where possible, eliminate the use of restrictive practices. Such processes should align with associated legislation including the Victorian Occupational Health and Safety Act 2004. This guideline sets out the expectations of what services are to consider in establishing policies and procedures in the use of restrictive interventions. However, local policies and procedures are required to consider the particular service setting, populations served and any other relevant local factors. Some of these specific considerations are addressed at the end of the guideline.

A designated mental health service under the Act includes those services that have an intake role for mental health consumers (for example emergency departments) Collaborative clinical governance arrangements between such services and mainstream mental health services need to be in place to ensure the legislative and best practice requirements are met. Such arrangements should ensure that:

- Consumers have a right to safe, high quality health care and to the provision of the information they need to participate in decisions about their care.
- Consumers have the right to openness and honesty of communication and to be cared for in an environment that fosters trust in those providing care.
- Clinicians and clinical teams have access to robust systems and processes to support them in providing safe, high quality care to consumers.

http://www.health.vic.gov.au/clinrisk/publications/clinical_gov_policy.htm

Key definitions

There are a number of terms employed throughout international mental health policy, legislation and literature to refer to people accessing mental health services. In this guideline, the terms 'person', and 'consumer' are used to reflect the language of recovery. Similarly, this document uses the term 'carer', which encapsulates relevant third parties including 'a support person', 'family', 'guardians', 'parents' or 'a nominated person'¹.

The Act closely regulates the use of '**restrictive interventions**'. Part 6 of the Act outlines when restrictive interventions can be used, who can authorize them and the monitoring of restrictive interventions when used. Section 3 of the Act defines 'restrictive interventions' as 'bodily restraint or seclusion'.

'**Bodily restraint**' is defined in the Act as 'a form of physical or mechanical restraint that prevents a person having free movement of his or her limbs, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's ability to get off the furniture' (s. 3).

While not considered contemporary practice, if cot sides or table tops are used with the intent to restrain, then this does constitute restraint and should be treated and recorded as such.

- '**Physical restraint**' involves the skilled², hands-on immobilisation or physical restriction of a person.
- '**Mechanical restraint**' involves the application of devices (including belts, harnesses, manacles, sheets and straps) to restrict a person's movement.

'**Seclusion**' is defined by the Act as the 'sole confinement of a person to a room or any other enclosed space, from which it is not within the control of the person confined to leave' (s. 3). Any confinement of a person that meets this definition is seclusion, even if the person agrees to, or requests, such confinement.

The Act applies to the use of restrictive interventions on all persons, regardless of age and legal status, who are receiving mental health services in a 'designated mental health service'³ (s. 3). These services are listed in the Mental Health Regulations 2014. The designated mental health services may provide mental health services in mental health in-patient services, community mental health services, some emergency departments and specialist mental health services for children, adolescents and older adults.

¹ A person nominated by the consumer to receive information and to support them while the consumer is under the Mental Health Act 2014. The nominated person assists a consumer to exercise their rights, and communicate their views and preferences. The nominated person is consulted at critical points during the consumer's treatment such as when a person enters and leaves a service (s.23).

² A person suitably trained and recognised by the organisation as such.

³ A 'designated mental health service' is a prescribed public hospital, a prescribed public health service, a prescribed denominational hospital or a prescribed privately-operated hospital, all within the meaning of section 3(1) of the Health Services Act 1988. It also includes a prescribed private hospital within the meaning of section 3(1) of the Health Services Act 1988 that is registered as a health service establishment under Part 4 of that Act and the Victorian Institute of Forensic Mental Health.

Prior to the use of restrictive interventions

Legal requirements

When can restrictive interventions be used?

Restrictive interventions may only be used on a person after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable (s. 105).

Each clinician has a responsibility to first use practices to prevent the use of restrictive interventions. Such practices rely on reducing the risk factors for harm as well as enhancing protective factors that promote a safe, secure, understanding and accepting environment. Internationally, initiatives to reduce the use of restrictive intervention have included developing leadership for organisational change; the use of data to inform practice; the involvement of a consumer and carer peer support workforce; the use of preventative interventions such as sensory modulation; workforce development; and debriefing (for an overview of evidence-based preventative practices see *Reducing restrictive interventions: Literature review and document analysis, 2013*

<http://docs.health.vic.gov.au/docs/doc/Reducing-restrictive-interventions:-Literature-review-and-document-analysis>).

Restrictive interventions may only be used if it is 'necessary to prevent imminent and serious harm to the person or to another person' (s. 110 and s. 113).

The determination of 'serious and imminent harm' is based on clinical judgment, clinical knowledge and the assessment of a person and their behaviour using evidenced based assessment tools. Clinical staff must assess and document that there is a high probability that the person will (or within the near future will) seriously harm themselves or another person and cite their rationale for this judgement.

In a matter of urgency, restrictive interventions may be applied to any person receiving services in a designated mental health service, regardless of legal status, under duty of care. Although such events are out of the scope of this guideline, the principles for reducing restrictive interventions (see pp. 5-6) still apply. However, if the person is a voluntary consumer, consideration must be given as to whether the person meets the criteria for compulsory status under the Act. If at any point an Assessment Order (s.28) is made, then the requirements of the Act apply as outlined in the legal requirements sections throughout this guideline.

Bodily restraint may also be used to 'administer treatment' or 'medical treatment' to a person (s. 113). Treatment is defined in s.6 of the Act and medical treatment in s. 7 of the Act.

Where are restrictive interventions regulated?

Part 6 of the Mental Health Act regulates the use of restrictive interventions (bodily restraint and seclusion) on a person receiving mental health services in a designated mental health service.

For the purpose of determining whether a person is receiving services 'in' a designated mental health service and whether Part 6 of the Mental Health Act applies, it will be those places or premises where people with mental illness are taken and detained for compulsory assessment or treatment in accordance with the Act. This will include acute mental health inpatient units and secure extended care units operated by the designated mental health service. It will also include emergency departments where the person is subject to an Order under the Mental Health Act (excluding people apprehended by police under section 351).

It also includes other medical and surgical inpatient facilities, whenever concurrent medical and mental health treatment is being provided.

Restrictive interventions in emergency departments

- A person may be brought into the ED under s. 351 of the Act (apprehension of the person by the police) if the person appears to have a mental illness and the action is required to prevent serious and imminent risk to the person or another person.
- If a restrictive intervention is used while the person is on a s.351, then its use is not regulated under the Act.
- If the person is assessed by a registered medical practitioner or a mental health practitioner and an Assessment Order is made (s.28), then from this point the requirements of the Act apply, which are outlined in the legal requirements sections throughout this guideline.

Advance statements

Division 3 of Part 3 of the Act allows for the writing of advance statements by consumers. These set out the person's preferences to treatment, strategies for avoiding the use of restrictive interventions. They may also include preferences about what should occur if the use of a restrictive intervention is required (s. 19). Advanced statements⁴ are a significant strategy in de-escalating the potential use of a restrictive intervention. Consumers should be asked whether they have made a statement and if not, be given the option of developing one.

How are restrictive interventions authorised?

- The use of restrictive interventions must be authorised by an 'authorised psychiatrist', or a 'delegate'⁵ determined by the authorised psychiatrist by written instruction.
- If an authorised psychiatrist or delegate is not immediately available, a registered medical practitioner or the senior registered nurse on duty may authorise a restrictive intervention (s. 111(1)(b) and s. 114(1)(b)). This covers the use of a restrictive intervention in an emergency department or a general area of the hospital where mental health services are being carried out.
- A registered medical practitioner or senior registered nurse must notify the authorised psychiatrist, or delegate, about the use of a restrictive intervention as soon as practicable⁶.
- An authorised psychiatrist, or delegate, must examine the person as soon as is practicable (s. 111(3) and s. 114(3)). This examination must involve an assessment of the person's mental health status and physical health status, a risk assessment and an assessment of the need to continue the restrictive intervention.
- If the authorised psychiatrist or delegate is not available to examine the person, he or she must arrange for a registered medical practitioner to examine the person as soon as practicable to decide whether continued use of the restrictive intervention is necessary, unless the practice has been ceased in the meantime.
- A registered nurse may approve the use of **physical restraint** if it is necessary as a matter of urgency to prevent imminent and serious harm to the person or another person; and an authorised psychiatrist, a registered medical practitioner or the senior registered nurse on duty is not immediately available to authorise the use (s. 115(1)).

4 These statements must be in writing, signed and witnessed by 'an authorised witness' (s. 20). An authorised witness includes a registered medical practitioner, mental health practitioner or a person who may witness the signing of a statutory declaration under section 107A of the Evidence (Miscellaneous Provisions) Act 1958 (s.3).

5 A 'delegate' may be a psychiatrist; a person to whom limited registration has been granted under section 66 of the Health Practitioner Regulation National Law to enable the person to undertake a period of postgraduate training or supervised practice in psychiatry or to undertake assessment or sit an examination approved by the Medical Board in relation to psychiatry; or a person to whom limited registration has been granted to enable the person to practice in psychiatry in an area of need under section 67 of the Health Practitioner Regulation National Law (s. 151 (1)).

6 "As soon as practicable" is frequently used in the Act but not defined. Clinically it would reflect a response that needs to occur almost immediately.

- The registered nurse must seek the authorisation of an authorised psychiatrist, a registered medical practitioner or the senior registered nurse on duty as soon as practicable (s. 115(2)).
- If a registered medical practitioner or senior registered nurse on duty authorises the use of physical restraint, that person must notify an authorised psychiatrist, or delegate, about the use of urgent physical restraint as soon as practicable (s. 114(2)).
- The registered nurse who has approved the use of a physical restraint on a person must immediately stop the use of physical restraint, if the registered nurse is satisfied that the continued use of the physical restraint is no longer necessary (s. 115(3)). This may well occur before the person is assessed by a medical practitioner but does not reduce the urgency for this to occur.

An 'Authority for use of restrictive interventions' form (MHA 140) needs to be completed by the person authorizing the use of a restrictive intervention. The registered nurse who approves the urgent use of physical restraint must complete the 'Approval for urgent physical restraint' form (MHA 141).

Best practice

Engagement with consumers and carers

The use of restrictive interventions needs to reflect trauma-informed care principles. Experiences of trauma are common among consumers and the use of restrictive interventions has the potential to be experienced as a traumatic event and/or trigger previous traumatic experiences. Responses may be extreme and may include symptoms such as flashbacks, hallucinations, dissociation, aggression, self-injury and depression. Advance statements and safety plans should be used to ensure care is trauma-informed. Carers can provide valuable and useful insights to assist mental health staff in this regard.

There is a greater chance of avoiding the use of restrictive interventions when there is the full and informed inclusion of consumers and carers in discussions about the use of restrictive interventions. Every effort must be made to routinely provide information sensitively to consumers and carers about the use of restrictive interventions. It is important for staff to listen, and respond to consumer and carer concerns about the use of restrictive interventions.

While it is appropriate to provide information about these interventions to carers in general terms, it is only where the consumer consents to the disclosure of specific planning involving the potential use of a restrictive intervention, that the details can be discussed with carers.

Medical assessment

Restrictive interventions should not be initiated in a designated mental health service unless a thorough medical assessment of the consumer has occurred. This should include identifying and documenting any substance use, recent medical procedures, surgical procedures, or conditions. However, if restrictive interventions have been applied to prevent serious and imminent harm prior to a medical assessment, a medical examination must be conducted as soon as practicable after the restrictive intervention has commenced. If the restrictive intervention was authorised by a registered practitioner or the senior registered nurse, s. 111(3) and s. 114(3) require the authorised psychiatrist to examine the person as soon as practicable after being notified. (for detail see **How are restrictive interventions authorised** on page 5)

Occasionally during a medical assessment a consumer is profoundly mentally unwell, unable or unwilling to give coherent responses to questions and violently opposed to being examined. While this makes adequate assessment difficult, as thorough an assessment as possible under the circumstances must take place.

Use of medication

The decision to prescribe medication before or during the use of a restrictive intervention is a medical decision. The use of medication to target symptoms of mental illness and reduce acute arousal and agitation (ie acute sedation) is appropriate. The use of medication to restrict movement (analogous to physical and mechanical restraint) is potentially hazardous and has no defined place in the Act or practice. Acute sedation and pharmacological treatments need to be very carefully considered with clear criteria for use determined by the

service, to guide judicious use of medications to relieve distress. Services need to ensure acute sedation policies are developed.

Nursing care planning

A collaborative nursing care plan that takes into consideration individual consumer needs, preferences and experiences, and carer views, of what interventions are most effective should be in place for all consumers. This should include the consumer consultant or peer worker if the current consumer approves of their involvement.

In some services consumer safety needs will be addressed in an integrated care plan. In others a specific “safety plan” may be developed. The extent to which planning can occur will vary depending on the individual. In an emergency, the opportunity to plan will be more limited, but a plan should be developed as soon as possible.

It is very unlikely that a nursing plan should include the care or intention to use a restrictive practice as it can only apply in emergency situations or after all possible interventions have been tried to reduce its need. If restrictive interventions are planned then care planning must include consideration or trial of all reasonable and less restrictive interventions (s. 105) and strategies to inform the person sensitively of the decision for the restrictive intervention (including why this decision has been made and how the consumer will be observed, managed and reviewed).

Staff training and education

Services will ensure there are a number of suitably trained registered nurses, registered medical practitioners and security staff available and trained in the service approved approach to restrict interventions. This would include all direct care staff and security staff. This should occur with new staff at orientation and all staff through refresher training, to ensure staff are familiar with the required practices.

Training must develop:-

- Proficiency in the use of evidence based preventative strategies (such as de-escalation techniques and the use of sensory modulation) to ensure restrictive interventions are used minimally.
- Proficiency in using approved techniques.
- An understanding of part 6 of the Act governing the use of restrictive interventions.
- An awareness of the consumer experiences of compulsory treatment and restrictive interventions.
- An understanding of the causes of aggressive or threatening behaviour.
- An awareness of the impact of staff behaviours and attitudes on consumers.
- Proficiency in undertaking observation and monitoring requirements.
- Proficiency in recognising signs of physical distress during the use of restrictive interventions.
- Proficiency in responding to escalating emergency responses and basic life support skills (CPR).
- An understanding of the standards set out in this guideline, and local policies and procedures.
- An understanding of the need to consider the use of restrictive interventions within a framework that promotes recovery-oriented practice and trauma-informed care.
- An understanding of how medication can be used to prevent and support a person who is acutely agitated.

Note that services should have in place policies that recognise that training requirements vary across disciplines depending on their functions and roles.

During the use of restrictive interventions

Legal requirements

Notification of the use of a restrictive intervention

After commencement of the use of a restrictive intervention, an authorised psychiatrist must take reasonable steps to notify relevant persons regarding the use of the restrictive intervention, the nature of the restrictive intervention and the reason for using it. The following persons should be notified where appropriate (s.107):-

- The nominated person
- A guardian;
- A carer, (if the authorised psychiatrist believes that the use of the restrictive intervention will affect the carer and the care relationship)
- A parent (if the person is under the age of 16 years)
- The Secretary to the Department of Human Services (if the person is the subject of a custody to Secretary order or a guardianship to Secretary order) (s. 107).

Monitoring the use of a restrictive intervention

An authorised psychiatrist must **examine** the person at least every four hours during the use of a **restrictive intervention** (s. 112(3) and s.116(4)). The time interval cannot be more than four hours. If the examination indicates the need for a greater frequency than every four hours, then this must occur. Each examination should be as thorough as the circumstances permit, and should cover the person's mental health status, physical health status, risk assessment and an assessment of the need to continue the restrictive intervention or if the use of the restrictive intervention can be ceased.

If it is not practicable for an authorised psychiatrist or delegate to conduct an examination at the frequency determined, then the examination can be delegated to a registered medical practitioner (s. 112(4) and s. 116(5)).

During the use of **seclusion**, a registered nurse or registered medical practitioner must undertake an assessment to determine the clinical observation frequency, but this should not occur less than every 15 minutes (s. 112(2)). If the observation indicates the need for more frequent observations (than every 15 minutes), then this must occur.

Clinical observation during seclusion is the purposeful gathering of information to inform clinical decision making. It is not passive surveillance. It involves gathering both objective and subjective information about the person from direct contact with the person (Nursing Observation Through Engagement in Psychiatric Inpatient Care: Department of Health Guideline, 2013,

<http://docs.health.vic.gov.au/docs/doc/Nursing-observation-through-engagement-in-psychiatric-inpatient-care>).

These observations should include but are not limited to the assessment of:

- breathing
- level of movement
- alertness and responsiveness
- levels of agitation
- the need to continue seclusion

Clinical decision making from this information may require more detailed physical health assessment, mental health status assessment or risk assessment; more frequent observations; or reporting of findings to a medical practitioner, authorised psychiatrist or delegate. The detail of what is required during purposeful observations should be outlined in the consumer's care plan.

During **bodily restraint**, a registered nurse or registered medical practitioner must clinically **review** the person every 15 minutes (s. 116(3)). The frequency must not be less than every 15 minutes. If the clinical review indicates the need for more frequent review (than every 15 minutes), then this must occur.

Clinical review is the purposeful gathering of information to inform clinical decision making. It involves gathering both objective and subjective information about the person from direct contact with the person. Registered nurses have specific responsibilities for the physical monitoring of bodily restraint. This involves monitoring vital signs and physical integrity. It includes but is not limited to:

- pulse
- temperature
- movement
- breathing
- skin integrity
- hydration, nutrition and elimination needs
- neurovascular observations of the restrained limb(s) (pulse, colour, warmth, sensation, movement and the experience of pain)
- alertness and responsiveness
- levels of agitation
- the need to continue bodily restraint

A person on whom a **bodily restraint** is used must be under **continuous observation** by a registered nurse or registered medical practitioner (s. 116(2)). This level of observation reflects the seriousness of the intervention and the potential for injury and death. The focus of attention during observation must be on the person's safety, dignity and any change in the person's physical, risk or mental health status. Continuous observations can involve two approaches.

- Constant (arm's length) observations occur with the person being in arm's length of a registered nurse or registered medical practitioner at all times:
- Constant (visual) observations occur with the person being within the vision of a registered nurse or registered medical practitioner at all times.

A collaborative decision of which continuous observation to use should be made by the registered nurse and/or registered medical practitioner concerned and documented in the nursing care plan. The person being observed should be made aware of the observation type, purpose and duration. Where possible they should be involved in the decision making about observations.

The 'Restrictive interventions observation form' (MHA 142) needs to be completed to maintain a record of clinical observations or reviews. This form must be completed by a registered nurse or registered medical practitioner undertaking the observations or reviews. A form must be completed for each type of restrictive intervention, to record the date and time that each type of restrictive intervention starts and ends, and the detail of the observations or reviews.

Meeting the needs of the person

The clinician who authorises⁷ the use of a restrictive intervention must ensure that the person's needs are met and the person's dignity is protected by the provision of appropriate facilities and supplies (s. 106). This should include:-

- Engaging with the person and providing explanation and reassurance.
- Protecting the person's self-respect and dignity.

⁷ Refer to section 'How are restrictive interventions authorised'.

- Meeting individual needs (based on culture, language, age, disability, religion, gender, sexuality, trauma history, vulnerability).
- Checking body alignment and that positioning remains appropriate.
- Reviewing vital signs.
- Preventing the development of adverse effects (e.g. pressure sores, abrasions, tissue damage, injury from immobilization, etc).
- Ensuring hydration and meeting nutritional needs. A fluid balance chart should be immediately commenced for a person who has been subject to a restrictive intervention.
- Providing adequate arrangements and assistance relating to elimination needs and personal hygiene.
- Ensuring the prescription and administration of medications.
- Providing the opportunity for physical exercise as appropriate.
- Ensuring clothing is comfortable and appropriate.
- Negotiating the removal of potentially dangerous items in a respectful manner and storing the items appropriately.

Best practice

Restrictive intervention⁸ techniques

Known adverse events associated with the use of restrictive interventions include

- death
- positional asphyxia
- compromised airway due to aspiration or choking
- neck or chest compression
- bruising
- dehydration
- loss of muscle strength and mobility
- incontinence
- needle stick injury
- deep vein thrombosis
- increase in psychological distress

Staff involved in restrictive interventions should be aware of the likelihood of increased agitation when a restrictive intervention is applied.

In considering **physical restraint**:

- Only physical restraint techniques approved by the designated mental health service should be used.
- The least restrictive physical intervention techniques required for the situation should always be applied.
- There is no physical restraint position that is absolutely safe.
- Physical restraint techniques which apply direct pressure to the neck, thorax, abdomen, back or pelvic area

⁸ Section 3 of the Act defines '**restrictive interventions**' as 'bodily restraint or seclusion'.

'**Bodily restraint**' is defined as 'a form of physical or mechanical restraint that prevents a person having free movement of his or her limbs, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's ability to get off the furniture' (s. 3).

'**Physical restraint**' involves the skilled, hands-on immobilisation or physical restriction of a person.

'**Mechanical restraint**' involves the application of devices (including belts, harnesses, manacles, sheets and straps) to restrict a person's movement.

are especially unsafe and should not be used under any circumstances.

- Whatever position is used there must be vigilant monitoring and managing of the risks.
- A senior registered nurse or registered medical practitioner as defined by the health service procedures needs to assume the responsibility for leading the team through the restraint process, and for ensuring that the airway and breathing are not compromised, and that vital signs are monitored for any physical deterioration.
- Physical restraint of consumers on the floor should be avoided.
- If the floor is used then this should be for the shortest period of time and for the purpose of gaining control of the situation.
- Prone (face down) restraint on the floor poses a risk of serious injury and should not be used (see Chief Psychiatrist Clinical Practice Advisory Notice: Practice of Prone Restraint, 2013
<http://docs.health.vic.gov.au/docs/doc/Chief-Psychiatrist-Clinical-Practice-Advisory-Notice:-Practice-of-Prone-Restraint>)
- If prone restraint is used, the registered nurse will ensure the person is not in a prone position for longer than 3 minutes.
- There is no completely safe time limit for the duration of any physical restraint technique. Physical restraint must be ceased as soon as possible.
- Physical restraint techniques that deliberately inflict pain must not be used.
- If the consumer experiences pain during the use of physical restraint, the technique should be altered immediately to achieve a pain free experience.
- Health services should ensure executive oversight is present over all restraint practice and policy development.
- All staff involved in restrictive interventions should be educated in the use of restraint and the risks associated with restraints.
- All restraints should be treated as an incident, reviewed and documented accordingly.

In considering **mechanical restraint**:-

- Only mechanical restraint devices approved by the designated mental health service should be used.
- Furniture (including beds with cot sides and chairs with tables fitted on their arms) should not be used with the intent to restrain a person.
- The device must be applied for the minimum amount of time required. Release of limbs from mechanical restraint must occur at least once per hour to prevent injury from immobilisation and to allow repositioning.
- If the restraint devices are not being used, remove them from the environment.

The use of restrictive interventions is clinically led. Security staff involved in the use of a restrictive intervention must act as directed by the senior registered nurse on duty or medical practitioner present, at all stages. The techniques used by security staff must comply with the practices stipulated in these guidelines and in local policies and procedures. Where there are concerns about the individual practices of staff involved, this must be reported to the appropriate manager responsible for the service.

A medical review must take place after the restrictive intervention has been ceased.

Communication

Information about the restrictive intervention must be provided to the consumer at the time the intervention is in use, including providing explanations and reassurance to the consumer. Consideration needs to be given to the involvement and support of a consumer consultant or peer support worker.

Staff must offer information on restrictive interventions to visitors and to other people (including other consumers) who have witnessed the use of a restrictive intervention, and provide an opportunity to discuss any

concerns they may have from witnessing the use. The privacy and confidentiality of persons involved should be maintained at all times.

Clinical documentation

The person's clinical record should demonstrate that the requirements of Part 6 of the Act, this guideline, and local policies and procedures have been met. This includes:-

- A description of the person's condition at the commencement of the intervention.
- The rationale for the use of restrictive interventions.
- Details arising from the nursing observations or review.
- Any medication or treatment provided and the response to treatment.
- The outcome of the initial and four-hourly medical examinations.
- Details of second opinions and/or case conference reviews.
- The nursing care plan.
- A copy of the MHA 142 observation form.
- Confirmation relevant persons have been notified of the use of the restrictive intervention under section 107

Case conference and second opinion

Where the restrictive intervention is used for extended periods of time or on a recurrent basis, it is good clinical practice to undertake a case conference. Consumers who repeatedly behave in a manner that threatens themselves or others and whose symptoms fail to respond to a full range of clinical interventions pose particular clinical challenges that require careful consideration and management. The reasons for the repeated behaviour should be explored and understood with the consumer. A thorough review of the person's history, treatments attempted and their duration, medication administered and responses, as well as the impact of contextual factors (e.g. organisational factors, the environment and team functioning) should be undertaken by the treating team (inclusive of consumer consultant involvement) and may be the subject of a case conference. This should include the consumer and carer directly involved where possible.

It is also good clinical practice to obtain a second opinion to review the consumer's management with prolonged or recurrent use of a restrictive intervention. This should be a second opinion external to the treating team.

In both instances a detailed care plan should be developed that:-

- Describes the behaviour in question.
- Identifies the precipitating and exacerbating factors.
- Outlines strategies aimed at reducing the behaviour and the need for a restrictive intervention.
- Outlines a graded series of responses.

After the use of restrictive interventions

Legal requirements

Release from restrictive interventions

If a clinician, who is able to authorise the use of a restrictive intervention, is satisfied that the continued use of the restrictive intervention is no longer necessary, then he or she must take immediate steps to release the person from the restrictive intervention (s. 109). This decision must be based on decision making stemming from active assessment of, and in collaboration with, the consumer.

If the use of a restrictive intervention needs to be reapplied, this marks the commencement of a new period of use and requires a new approval and/or authorisation process.

Reporting to the Chief Psychiatrist

An authorised psychiatrist must give a written report to the Chief Psychiatrist on the use of any restrictive intervention (s. 108(1)). This report must contain the details required by the Chief Psychiatrist and be given to the Chief Psychiatrist within the time stipulated (s. 108). In practice, this information is entered monthly onto the Client Management Interface (CMI) database in each service.

Best practice

Post restrictive intervention consumer support

- It is a priority to review the use of a restrictive intervention and to plan collaboratively with the consumer to minimise the future need for a restrictive intervention. The consumer's understanding and experience of the incident should be explored, once the person is able and willing to discuss the incident leading to the use of a restrictive intervention, at a time of their choosing.
- A restrictive intervention is a potentially traumatic experience that requires sensitivity and skill in discussing. The consumer needs to be asked if they would like to discuss his or her experience of the restrictive intervention.
- The purpose of a post restrictive intervention consumer support session is to provide an opportunity for the person's experience of the episode to be acknowledged and heard. Attempts to justify the decision to use a restrictive intervention may be counter-productive and should be avoided.
- The consumer should be given a choice as to who he or she would like to discuss their experience with, wherever possible. This may include access to an available peer support network.
- A post restrictive intervention support session should also be offered to other persons, as appropriate, including carers and other consumers who witnessed the event.

Experience of care review

Following the use of a restrictive intervention, a formal systemic review should occur as soon as possible with input from a range of staff including the unit manager, senior registered nurses, a consultant psychiatrist, any staff involved and carer/consumer consultants from the service concerned. Wherever possible, the consumer and their carer should be supported and encouraged to participate in the review.

The aim of the experience of care review is to:-

- Involve the consumer considering what else might have been done to prevent or minimise the use of a restrictive intervention.
- Review the use of the restrictive intervention in relationship to the factors that precipitated its use.
- Identify preventative strategies trialled to prevent the restrictive intervention and the reasons for failure.
- Review compliance with the Act.

- Review system-wide management issues that may need addressing to prevent further use of restrictive interventions.
- Ensure that any systemic issues that would ordinarily generate an incident report are appropriately documented and escalated for a) information and b) remedial action.

Any systemic issues identified need to be forwarded to the relevant safety and quality improvement committee for attention. Restrictive intervention monitoring should be included in the ongoing quality assurance program of the designated mental health service. Findings from this review should inform the development of training programs.

Other quality-improvement activities should include local clinical audits based on the knowledge and application of Part 6 of the Act, local policies and procedures, and this guideline (see health service self-assessment suggestion below⁹). These are leadership activities to enhance strategies to reduce the use of restrictive interventions.

⁹ Health service self-assessment of restrictive interventions

Standard 1: Compliance with statutory requirements

There are established documented procedures to ensure compliance with the requirements specified in this guideline.

Policies and procedures are reviewed by the service to ensure compliance with the above requirements.

Standard 2: Restrictive interventions are comprehensively reviewed

There is an established procedure for reviewing restrictive interventions used in the service.

Practice improvements are made in light of reviewing restrictive interventions via the health service clinical governance framework.

Developing local policies and procedures

All services should have local policies and procedures which take into account the particular service setting, populations served and any other relevant local factors. Specific considerations should be given to the following.

Gender safety and sensitivity

Sensitivity to gender-specific needs is crucial. Consumers may have different preferences about the gender of staff involved in prevention and early intervention, as well as the use of a restrictive intervention. The consumer's preferences should be sought and responded to. Arrangements for clothing, searches for dangerous objects, toileting and review should also be undertaken in regard to gender sensitivity. Consideration should also be given to the possibility of pregnancy in female consumers and the implications of this, especially if medications contraindicated during pregnancy are being considered.

It is important to remember a key component of providing gender sensitive care is to understand trauma and how it manifests in people when they are in acute distress.

Intellectual disability or acquired brain injury

Where a person has an intellectual disability or acquired brain injury, his or her behaviour may be the principal means of communication, particularly where his or her ability to communicate may also be impaired by mental illness. Problematic behaviour, where possible, should be assessed for meaning before making decisions to use a restrictive intervention.

It should be anticipated that it is not uncommon for these consumers to demonstrate a low frustration tolerance and at times poor impulse control. People with cognitive impairment often have difficulty in understanding the rationale for the use of a restrictive intervention and may react with an escalation in agitation during this process. Carers' views should be taken into account regarding the use of a restrictive intervention and their preferences regarding notification of such events.

It is important, wherever possible, for the nature of the intervention and the reasons for it to be explained at a level the person is able to comprehend. All the above points should be outlined in a detailed care plan.

Older persons

Consideration should be given to the ramifications of the use of a restrictive intervention for this age group. There is a marked increase of bone fractures and loss of skin integrity when applying and maintaining a restrictive intervention for older persons, as well as exacerbation of underlying confusion and agitation. Special consideration should be given to the assessment for underlying or emerging medical conditions impacting on the person's mental state and behaviour.

Carers views should also be taken into account regarding the use of a restrictive intervention and their preferences regarding notification of such events. Wherever possible, older adults should receive one-to-one nursing care in preference to using a restrictive intervention. All the above points should be outlined in a detailed care plan.

Children and adolescents

The developmental status of a young person should be a consideration in any decision to use a restrictive intervention. The use of a restrictive intervention with children under the age of 12 years should be avoided. Restrictive interventions must be used with caution when they involve adolescents because in most cases their musculoskeletal systems are immature, which elevates the risk of injury.

The carer, of a young person must be informed of the use of a restrictive intervention as soon as practicable. A decision to involve a carer, or other relevant third parties in the debriefing process must take into account the young person's capacity to consent to their involvement.

Aboriginal consumers

Aboriginal consumers may perceive or interpret the use of a restrictive intervention differently depending on their cultural backgrounds and personal experiences of colonisation.

Special care must be taken to achieve effective communication, first to avert the use of the restrictive intervention if possible, and second to minimise the trauma of the intervention to the consumer, both during and after the intervention. It is important to be aware that communication problems in themselves may lead to unnecessary restrictive interventions. Cultural advisors should be used, if possible, as a means to minimise the potential for miscommunication and misunderstanding.

Culturally and linguistically diverse (CALD) consumers

Restrictive interventions may be more traumatic and potentially more dangerous for people who are unable to understand what is happening or unable to communicate their questions or concerns. Consumers may perceive or interpret the use of a restrictive intervention differently depending on their cultural backgrounds and personal experiences such as being a refugee or being a survivor of abuse or torture.

Special care must be taken to achieve effective communication, first to avert the use of the restrictive intervention if possible, and second to minimise the trauma of the intervention to the consumer, both during and after the intervention. It is important to be aware that communication problems in themselves may lead to unnecessary restrictive interventions. Interpreters should be used (telephone or face-face) or cultural advisors, if possible, as a means to minimise the potential for miscommunication and misunderstanding.

Consumers with sensory impairment

The use of a restrictive intervention may also be more traumatic and potentially more dangerous for those who are unable to fully understand what is happening or unable to communicate their questions or concerns due to sensory impairment. Specific interventions, such as the physical restraint of an auditory impaired person's hands, may also prevent effective communication.

Special care must be taken in these situations to achieve effective communication. The use of carers who are familiar with the communication needs of the consumer should be considered in these situations.

Related guidelines and resources

Framework for recovery-oriented practice, 2011

<http://docs.health.vic.gov.au/docs/doc/Framework-for-Recovery-oriented-Practice>

Creating Safety, project documents and report, 2009

http://www.health.vic.gov.au/chiefpsychiatrist/documents/creatingsafety/creating_safety_project_report.pdf

<http://www.health.vic.gov.au/chiefpsychiatrist/creatingsafety/index.htm>

Creating safety, seclusion literature review, 2007

<http://www.health.vic.gov.au/chiefpsychiatrist/documents/creatingsafety/litreview.pdf>

Chief Psychiatrist Clinical Practice Advisory Notice: Practice of Prone Restraint, 2013

<http://docs.health.vic.gov.au/docs/doc/Chief-Psychiatrist-Clinical-Practice-Advisory-Notice:-Practice-of-Prone-Restraint>

Department of Human Services, Senior Practitioner Physical Restraint Direction Paper, 2011

<http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/reports-publications/physical-restraint-direction-paper-senior-practitioner>

National Safety Priorities in Mental Health: a National Plan for Reducing Harm, 2005

<http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-safety>

The Royal Australian and New Zealand College of Psychiatrists, Minimising the use of seclusion and restraint in people with mental illness, 2010

https://www.ranzcp.org/Files/ranzcpattachments/Resources/College_Statements/Position_Statements/ps61-pdf.aspx

Providing a safe environment for all: Framework for reducing restrictive interventions, 2013

<http://docs.health.vic.gov.au/docs/doc/Providing-a-safe-environment-for-all:-Framework-for-reducing-restrictive-interventions>

Reducing restrictive interventions: Literature review and document analysis, 2013

<http://docs.health.vic.gov.au/docs/doc/Reducing-restrictive-interventions:-Literature-review-and-document-analysis>

Chief Psychiatrist's guidelines

<http://www.health.vic.gov.au/mentalhealth/cpg/>

About Chief Psychiatrist's guidelines

The information provided in this guideline is intended as general information and not as legal advice. Service providers should obtain independent legal advice if they have queries about individual cases or their obligations under the Mental Health Act 2014.