Restrictive interventions

Chief Psychiatrist's guideline – April 2024

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In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people.

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Contents

Purpose and introduction

This guideline has been developed to assist designated mental health services meet their legal obligations and understand the Chief Psychiatrist's expectations of best practice when using restrictive interventions. This includes ethical and human rights considerations.

It has information on:

- legislative definitions of restrictive interventions under the *Mental Health and Wellbeing Act 2022*
- legal requirements under the Mental Health and Wellbeing Act that must be met before, during and after a restrictive intervention
- contemporary understandings of clinical best practice for restrictive interventions, including an increased emphasis on ethical and human rights considerations
- the rights of people receiving mental health treatment and care in Victoria.

Restrictive interventions are distressing, traumatising and non-therapeutic, leaving people who experience them with long-term impacts. For this reason, Victoria has a legislative framework and oversight regime to regulate restrictive interventions and to ensure they are prevented or only ever used as a last resort after other options were tried or considered to be unsuitable.

The Act is the foundation for this regulatory framework. It defines the different types of restrictive interventions, the purposes for which they are permitted, and the requirements that must be followed when deciding to use a restrictive intervention.

The Act defines core consumer and carer rights that must be respected and upheld when restrictive interventions are used. It also establishes the statutory authorities that enforce legislation and support services to implement changes that make restrictive interventions less likely or avoidable entirely.

The Chief Psychiatrist is Victoria's main authority for overseeing restrictive interventions. The Chief Psychiatrist has statutory powers and responsibilities under the Act to:

- monitor restrictive interventions
- investigate instances where there was a breach of the Act during the use of a restrictive intervention
- assist services to comply with the legislative requirements when using restrictive interventions.

The Chief Psychiatrist has issued this guideline as part of their oversight and leadership role. The guideline provides information and advice that will assist mental health clinicians to understand the mandatory legal requirements when considering using restrictive interventions. It also outlines improvements that can be made in day-to-day work to achieve best practice, including ethical and human rights considerations.

Several new developments are reflected in this guideline, stemming from:

- replacing the *Mental Health Act 2014* with the *Mental Health and Wellbeing Act 2022*
- the recommendations of the 2021 Royal Commission into Victoria's Mental Health System to modernise the mental health and wellbeing system and make it safer and more responsive for people who use it and work in it including:
  - expanding the Chief Psychiatrist's jurisdiction to encompass new aspects and settings of restrictive interventions, such as chemical restraint and mental health and wellbeing services in custodial settings

  - establishing new statutory bodies that the Chief Psychiatrist will coordinate their actions with to promote quality and safety, such as the Mental Health and Wellbeing Commission and the Chief Officer for Mental Health and Wellbeing
  - developing a strategy to reduce and eventually eliminate restrictive interventions over a 10-year period
  - defining chemical restraint as a restrictive intervention that service providers must record and report to the Chief Psychiatrist to enable its oversight for the first time in Victoria
  - strengthening consumer rights and service provider obligations so proper consideration is given to the preferences and needs of consumers and their carers, family, friends and supporters
  - introducing automatic access to a non-legal advocacy service for people subjected to restrictive interventions and compulsory assessment and treatment (the primary provider of this service is Independent Mental Health Advocacy [IMHA]).

The Chief Psychiatrist is aware that the term 'restrictive interventions' is offensive to some after hearing the views of people with lived and living experience while developing this guideline. However, to avoid confusion and remain consistent with the language used in the Mental Health and Wellbeing Act, the term 'restrictive interventions' will be used in this guideline when making a direct reference to the Act. In the best practice sections of this guideline, the term 'restrictive practices' has been adopted over 'restrictive interventions' to reflect stakeholders' views. The Chief Psychiatrist will be increasingly adopting the language of 'restrictive practices' over time.

This guideline was prepared with the participation of:

- people with a lived and living experience of the mental health system (including the experience of restrictive interventions)
- senior mental health clinicians
- senior clinicians in various disciplines of health care
- legal experts
- other stakeholders.

By including this broad range of perspectives, the guideline aims to capture the diversity of knowledge and experience that is required for the legal and contemporary use of restrictive interventions to safeguard the rights and dignity of people living with mental illness.

The Chief Psychiatrist is grateful to a member of the expert advisory group who shared their experience and gave permission to include it in this guideline. It was a privilege to be trusted with their story.

Personal story: Family, Carer and Supporter Lived Experience Advisor

My 14-year-old son had taken a high dose of benzodiazepine and was behaving recklessly and was self-harming. So I called Triple Zero (000) and a highly traumatic police response ensued. It ended with him being held face down by 4 police officers. He was yelling 'I can't breathe'. This was 9 years ago, and I still play it over in my head. Not long after, I was diagnosed with PTSD.

At the hospital, things changed. We had an amazing nurse in the emergency department. My son travelled alone with one of the police officers in the ambulance, and I followed in an Uber. When I arrived at the hospital, my son was still physically restrained, highly distressed and alone. He was swearing at a doctor, who told him to calm down and behave himself – an understandable response but not particularly helpful for defusing the situation. The nurse suggested the doctor leave and come back in 5 minutes. She then dropped down to eye level with my son and spoke quietly. She said something like:

> *This is a terrible situation. You must be scared. Can we work together to get these straps off your arms and legs? I understand you don't like the doctor, but if you yell at him, the restraints will stay. Can I help you not to raise your voice? So here is the plan … If what the doctor is saying is making you angry, then wiggle your fingers, and I will step in and talk to the doctor.*

It worked. She built trust and acted as a translator between my son and the doctor. With her guidance and support, he soon calmed down, had his wounds attended to, and the restraints removed.

She then turned to me and spoke:

> *This must be so hard for a mum. Do you need some support? How about I call the social worker to speak with you?*

The social worker referred me to Family Drug Help and SHARC*, who have been my lifeline ever since. I attended a peer-led training program, which was particularly helpful. It provided me with skills to parent more effectively. I was taught about dignity in risk, setting boundaries and maintaining communication. The course helped save my son's life several times because we built trust through improved communication. He would call me when he was in strife or thinking about self-harm.

I often think about the life-changing impact that nurse had on our family that night.

* Self Help Addiction Resource Centre

Principles

Mental health and wellbeing principles

Part 1.5 of the Mental Health and Wellbeing Act contains mental health and wellbeing principles to guide service providers with upholding the dignity and autonomy of people living with mental illness or psychological distress. Service providers must make all reasonable efforts to comply with these principles and give proper consideration to the principles when making a decision.

The mental health and wellbeing principles require consumers and carers to be treated with respect and dignity. Care is to be given in the least restrictive way reasonably possible; medical and other health needs are to be accommodated and diverse needs are to be actively considered. Furthermore, gender safety and cultural safety are to be given priority, and families, carers and supporters are to be included. Consumers must be supported in making decisions on their treatment and care.

Decision-making principles

There are 5 decision-making principles at Part 3.1 of the Act that are relevant to restrictive interventions. These include the:

- care and transition to less restrictive support principle (s 79)
- consequences of compulsory assessment and treatment and restrictive interventions principle (s 80)
- no therapeutic benefit to restrictive interventions principle (s 81)
- balancing the harm principle (s 82)
- autonomy principle (s 83).

Other important principles

Other principles that overlap with, or are an extension of, those outlined above that service providers must consider include:

- promotion and protection of rights for consumers, families and carers, along with their empowerment to exercise those rights
- receiving safe, respectful, high-quality health care and receiving information to take part in decisions about one's own care
- access to robust systems and processes for clinicians and clinical teams that enables them to provide compassionate, safe and high-quality care
- honest and open communication with consumers and providing care in an environment and manner that fosters trust in those delivering the care
- collaboration between consumers, families, carers, supporters, clinicians, peer support workers, consumer consultants, Aboriginal health liaison officers and Koorie mental health liaison officers to reduce, and where possible eliminate, restrictive practices
- trauma-informed care, including an acknowledgement of the impact of trauma and the relevance this has to pathways for recovery (attention should be given to recognising the signs and symptoms of trauma among consumers, families, carers and staff; trauma-informed principles should be integrated into policies, procedures and practices)

- an understanding of co-occurring mental health and alcohol and other drug concerns, including recognising when a consumer is substance-affected and/or withdrawing and how to manage this in a safe, non-stigmatising way
- where a consumer's rights are compromised, helping them to lodge a complaint in keeping with their rights and preferences and putting steps in place to prevent future harm.

Key roles

Chief Psychiatrist's role

The Chief Psychiatrist is an independent statutory officer with powers and responsibilities prescribed by the Act to uphold the quality and safety of clinical mental health services in Victoria.

As part of their oversight and leadership role, the Chief Psychiatrist:

- monitors clinical mental health service providers to ensure compliance with the Act
- investigates incidents when the safety or wellbeing of a person was endangered while receiving a mental health and wellbeing service
- reviews and audits service provision to find and resolve quality and safety issues
- publishes guidelines on clinical best practice
- promotes the rights of people receiving a mental health and wellbeing service.

Other entities involved in governing restrictive interventions

In addition to the Chief Psychiatrist, the entities that make up the quality and safety architecture of Victoria's mental health and wellbeing system include the Chief Officer for Mental Health and Wellbeing, the Mental Health and Wellbeing Commission and the Mental Health Improvement Unit in Safer Care Victoria. These entities are defined either by the Act (Chief Officer for Mental Health and Wellbeing; the Mental Health and Wellbeing Commission) or the recommendations of the Royal Commission into Victoria's Mental Health System (Mental Health Improvement Unit).

The Chief Psychiatrist works with these entities to ensure the overall governance of restrictive interventions is coordinated and effective.

The functions of the **Chief Officer for Mental Health and Wellbeing** in relation to restrictive interventions are to:

- set targets to reduce and ultimately eliminate the use of restrictive interventions in mental health and wellbeing services
- develop, monitor and report on appropriate measures to progressively reduce and ultimately eliminate the use of restrictive interventions in mental health and wellbeing services.

The functions of the **Mental Health and Wellbeing Commission** in relation to restrictive interventions are to:

- monitor and report on the performance, quality and safety of the mental health and wellbeing system, including the use of restrictive interventions
- report on the use of restrictive interventions compared with the targets set by the Health Secretary.

The Mental Health and Wellbeing Commission replaces the Mental Health Complaints Commission but retains the function of handling complaints about Victorian publicly funded mental health and wellbeing services.

The functions of the **Mental Health Improvement Unit (Safer Care Victoria)** in relation to restrictive interventions are to:

- promote learning cultures and provide workforce training for building professional skills that reduce a reliance on restrictive interventions.

Key definitions

There are several terms used in mental health policy, legislation and academic 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' and 'parents'.

Aboriginal in this document refers to both Aboriginal and Torres Strait Islander people.

Advance statement of preferences is a document that sets out a person's preferences in relation to their treatment, care and support if the person becomes a patient under the Act (s 57).

Authorised psychiatrist is a psychiatrist appointed by a designated mental health service under s 328 of the Act to carry out the functions and exercise the powers conferred on an authorised psychiatrist under the Act or any other Act and support the Chief Psychiatrist to perform the Chief Psychiatrist's functions under the Act. An authorised psychiatrist can delegate a function or power to certain individuals under s 329 of the Act.

Best practice refers to standards of care that are recommended by research, professional literature and professional experience. Best practice in this guideline is an extension of, or complements, the legal requirements in the Act. Best practice should be followed, where possible, to ensure safe and high-quality clinical practice in relation to restrictive interventions that include ethical and human rights considerations.

Carer has the same meaning as in s 3 of the *Carers Recognition Act 2012* and is defined by the care relationship between 2 individuals. It does not include a parent if the person to whom care is provided is under the age of 16 years.

Clinical mental health service provider means either:

- a designated mental health service
- a mental health and wellbeing service provider that provides mental health and wellbeing services in a custodial setting, or
- any other prescribed entity or prescribed class of entity.

Consumer means a person who either:

- has received mental health and wellbeing services from a mental health and wellbeing service provider
- is receiving mental health and wellbeing services from a mental health and wellbeing service provider
- was assessed by an authorised psychiatrist and was not provided with treatment, or
- has sought or is seeking mental health and wellbeing services from a mental health and wellbeing service provider and was not or is not provided with those services.

Designated mental health service means a prescribed public hospital, prescribed public health service, prescribed denominational hospital, prescribed privately operated hospital, prescribed private hospital that is registered as a health service establishment under the Act, the Victorian Institute of Forensic Mental Health, a service temporarily declared to be a designated mental health service or a declared operator (per s 3(1) of the Act).

Emergency department (ED) is the part of a hospital that provides 24-hour emergency care to patients who need urgent medical attention for severe injuries or illness. Most public hospitals in Victoria have an emergency department.

Family refers to family of origin or family of choice.

Families, carers and supporters refers to the network of people that support consumers with their mental health and wellbeing. Throughout this document practice that is family/carer/supporter-inclusive is promoted. This inclusion must always be with the consent of the consumer or align with the information-sharing principles of the Act.

Legal requirement refers to obligations that are mandatory and stipulated in the Act, and therefore must be adhered to.

LGBTIQA+ refers to lesbian, gay, bisexual, trans and gender diverse, intersex, queer/questioning, asexual. For comprehensive definitions refer to the LGBTIQ inclusive language guide <https://www.vic.gov.au/inclusive-language-guide>.

Mental health and wellbeing service is a service performed for the primary purpose of: improving or supporting a person's mental health and wellbeing; assessing, or providing treatment, care or support to, a person for mental illness or psychological distress; or providing care or support to a person who is a family member, carer or supporter of a person with mental illness or psychological distress.

Nominated support person is a person nominated by a patient under Part 2.6 of the Act to support them, to advocate for them and receive information and be consulted about them in line with the Act.

Opt-out non-legal advocacy service is a free service that provides representation for eligible consumers or supports them in self-advocacy. Eligible consumers include people who are placed on compulsory treatment orders or are at risk of being placed on such order and people who are subjected to a restrictive intervention. Access to a non-legal advocacy service is automatically activated when a restrictive intervention is registered on the health service's database (CMI-ODS). Consumers who do not wish to access this service can opt out. The primary provider of this service is IMHA.

Patient means an assessment patient, a court assessment patient, a temporary treatment patient, a treatment patient, a security patient or a forensic patient (s 3(1)).

Restrictive intervention means 'seclusion, bodily restraint or chemical restraint' (s 3(1)):

- **Seclusion** means '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'.
- **Bodily restraint** means 'physical restraint, or mechanical restraint, of a person'.
  - **Physical restraint** means 'the use by a person of their body to prevent or restrict another person's movement but does not include the giving of physical support or assistance to a person in the least restrictive way that is reasonably necessary to—
    (a) enable the person to be supported or assisted to carry out daily activities; or
    (b) redirect the person because they are disoriented'.
  - **Mechanical restraint** means 'the use of a device to prevent or restrict a person's movement'.
- **Chemical restraint** means 'the giving of a drug to a person for the primary purpose of controlling the person's behaviour by restricting their freedom of movement but does not include the giving of a drug to a person for the purpose of treatment or medical treatment'.

The provisions relating specifically to restrictive interventions are set out in Part 3.7 of the Act.

Treatment for a mental illness is received by a person if professional skill is used to remedy or alleviate the person's mental illness or to alleviate the symptoms and reduce the ill effects of the person's mental illness.

- Treatment includes electroconvulsive treatment and neurosurgery.
- Detention is not treatment.

To avoid doubt, treatment means treatment for mental illness.

Urgent care centres in Victoria are public rural health services equipped to provide first-line emergency care to people. They share attributes with emergency departments in cities and larger towns but do not provide the same level of emergency care.

Young person is a person who is:

- under the age of 18 years in Chapter 3 of the Act
- at least 12, but not more than 25 years of age in Chapter 16 of the Act.

Chemical restraint

In response to recommendations 42 and 54 of the Royal Commission, the Victorian Government developed a new Mental Health and Wellbeing Act. For the first time in Victoria, this Act regulates the use of chemical restraint.

Chemical restraint, as defined in this Act, means the giving of a drug to a person for the primary purpose of controlling the person's behaviour by restricting their freedom of movement but does not include the giving of a drug to a person for the purpose of treatment or medical treatment.

There are other state and federal Acts that have definitions of chemical restraint (for example, the *Disability Act 2006* and the *Aged Care Act 1997*) that are different from the one outlined here and are regulated by other entities. There may be instances where administering a medication meets the definition for recording and reporting in more than one Act. The reporting of chemical restraint to the Chief Psychiatrist within the meaning of the Mental Health and Wellbeing Act does not absolve a service of its responsibilities in reporting to those other entities based on relevant legislation and definitions.

The Act requires certain legal requirements to be met (refer below) before chemical restraint can be authorised for a person receiving a mental health and wellbeing service in a designated mental health service or being transported to, from or within a designated mental health service. Chemical restraint can only be used in these circumstances for a permitted purpose (s 127), namely that of preventing imminent and serious harm to the person or another person (s 126 (a)). It is only if those conditions are met that the definition of chemical restraint within the meaning of the Act applies.

The Chief Psychiatrist is responsible for overseeing chemical restraint to ensure it is used by designated mental health services within the strict parameters set out in the Act. Chemical restraint must be:

- recorded and reported in all parts of designated mental health and wellbeing services where it occurs
- reported to the Chief Psychiatrist, as described in section 5 of the *Chief Psychiatrist's reporting directive for restrictive interventions* <https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions>.

The Act provides for registered medical practitioners (including those at non-designated mental health services) to authorise chemical restraint for the purposes of transport to or from a designated mental health service where necessary to prevent imminent and serious harm.

Where a registered medical practitioner at a non-designated mental health service authorises chemical restraint in these circumstances, they must comply with the requirements Division 1 and 3 of Part 3.7 of the Act, including that chemical restraint only be used if necessary to prevent imminent and serious harm and where all reasonable and less restrictive options have been tried or considered and found unsuitable.

Registered medical practitioners at non-designated mental health services may choose to complete the MHWA 143 form (authority for chemical restraint) to assist with documenting their decision to authorise chemical restraint (noting that not all fields will be relevant to them). If the form is not used, the decision should be appropriately documented elsewhere. Copies of these documents should be provided to the designated mental health service as part of the handover of the person's care.

More information about medication use is below in the section 'Things to consider before using a restrictive intervention'.

The Chief Psychiatrist recognises that the definition of chemical restraint in the Act may not be the way the term is commonly used or a definition that all stakeholders wished to see.

Determining what is chemical restraint

Administering medication (or a 'drug' in the Act) should be understood as chemical restraint when the primary purpose of administering the medication is to exert control over a person's behaviour. There may be ambiguity when the medication has the effect of both controlling behaviour and treating the underlying cause. In situations of ambiguity, the primary purpose must be considered. The documentation in the medical record must outline the rationale for why medication use was or was not recorded as chemical restraint.

Box 1 provides a checklist to assist with determining when medication administration should be understood as chemical restraint and is therefore reportable to the Chief Psychiatrist (for further details, see also Appendix: Determining when medication use requires reporting to the Chief Psychiatrist).

Box 1: Determining what is chemical restraint

When determining what is chemical restraint within the meaning of the Act and therefore what is reportable to the Chief Psychiatrist, consider these 4 questions:

1. Is this practice taking place in a designated mental health service?
2. Is the person receiving a mental health and wellbeing service?
3. Is there a permitted purpose for this practice? That is, to prevent imminent and serious harm to that person or another person or to administer treatment or medical treatment to that person (see below).
4. Is the primary purpose of the 'giving of a drug' to control behaviour by restricting freedom of movement?

If the answer to *all* these questions is 'yes', the practice constitutes chemical restraint and is therefore reportable to the Chief Psychiatrist.

Instances where anaesthetic agents are administered – especially where a person is rendered unconscious and is intubated – constitute chemical restraint, if for the primary purpose of controlling behaviour. Instances that may need to be recorded and reported as chemical restraint include (1) the giving of higher than usual maximum doses of regular medications to a person known to have a diagnosed mental illness and (2) the administration of psychotropic agents, particularly via intramuscular (IM) or intravenous (IV) routes, to a person who is suspected but not known to have a diagnosed mental illness, and where the medication is not for the purposes of psychiatric treatment for a mental illness.

Using published protocols to manage acute arousal is encouraged but does not preclude that this may on some occasions also be considered chemical restraint. Prescribing and administering medications at dosages or a frequency greater than the maximum level described in such protocols may be considered chemical restraint depending on the circumstance.

Consumers with lived experience consulted in the writing of this guideline and related material have referenced occasions when medications are used for their sedating effect without consent and when there is no permitted reason as outlined in Box 1; that is, the person is not presenting a serious and imminent risk of harm to themselves or others. This practice may be experienced as chemical restraint, although it does not fit the legal definition in the Act. This may be an example of where the

decision-making principles have not been given proper consideration. A service may therefore need to justify its decision to not record medication prescription and administration as chemical restraint. The service may be asked to provide the evidence base for the intervention in these instances.

Emergency departments and urgent care centres of designated mental health services

The legal requirements and best practice advice set out in this guideline also apply to the emergency departments (EDs) and urgent care centres (UCCs) of designated mental health services whenever a person is receiving a mental health and wellbeing service.

Receiving a mental health and wellbeing service in an ED or UCC

In the context of EDs and UCCs, the circumstances when a person is receiving a mental health and wellbeing service can include:

- being brought under the care and control of police with or without ambulance services for a mental health examination under s 232 of the Act – similar to the powers in the previous 2014 Mental Health Act in s 351 (further details below in section 'Transfer of care and control')
- voluntarily seeking mental health support
- being brought in by a family member or friend for a mental health assessment and/or support (for example, parents bringing in a child)
- a compulsory patient awaiting a bed in an inpatient mental health unit (for example, a patient is placed on an assessment order in the community or someone on a Community Treatment Order (CTO) is varied to an inpatient Treatment Order (TO))
- presenting initially with a non–mental health condition but subsequently being assessed as requiring a mental health and wellbeing service.

The above examples are not exhaustive but illustrate that a professional service has been received for the purpose of 'assessing, or providing treatment, care or support to a person for mental illness or psychological distress' (Part 1.2.3 of the Act). Once a practitioner has begun their consideration of whether to authorise a restrictive intervention, the obligations of the Act apply.

Intoxication with alcohol and other drugs

When someone presents to an ED or UCC with known or suspected intoxication with alcohol or other drugs, determining whether they are or will be in receipt of a mental health and wellbeing service depends on the primary purpose for their presentation as described above.

Clinicians must hold in tension that under Part 1.2.4 s 2 (l) of the Act, a person is not considered to have mental illness by reason only that the person uses drugs or alcohol and that Part 1.2.4 s 3 that states that subsection (2) (l) does not prevent the serious temporary or permanent physiological, biochemical or psychological effects of using drugs or alcohol from being regarded as an indication that a person has mental illness.

Further, the 'health needs principle' in s 22 of the Act states that:

> *The medical and other health needs of people living with mental illness or psychological distress are to be identified and responded to, including any medical or health needs that are related to the use of alcohol or other drugs. In doing so, the ways in which a person's physical and mental health needs may intersect should be considered.*

Clinicians will form a judgement about whether the reason for the presentation is better accounted for by a suspected mental illness or by a medical condition including an acute brain syndrome. If a mental illness is suspected and a restrictive intervention used, having established a permitted reason for doing so, this is reportable to the Chief Psychiatrist, even if the effect on behaviour of alcohol or the drug is brief and time limited.

Transfer of care and control

The Act requires that the person's care and control is transferred to a registered medical practitioner, an authorised mental health practitioner or a registered nurse as soon as reasonably practicable. At this point the care and control of police ends.

If care and control has not yet been transferred but restrictive interventions may be required, consideration by an authorised psychiatrist, registered medical practitioner, nurse in charge or a nurse practitioner whether to authorise the use or continued use of a restrictive intervention (including with the assistance of police) will enliven the monitoring and reporting requirements of the Act. At this point, care and control is taken to have transferred to the assessing clinician and police will no longer have care and control of the person. Police may be requested to stay and assist in managing any ongoing safety risks.

There is no capacity for concurrent or shared care and control between medical staff and other authorised persons (such as police). Once care and control has been transferred to the assessing clinician it cannot be transferred back to police. Where a person is taken to an ED that is not attached to a designated mental health service, the restrictive intervention reporting requirements of the Act do not apply. This also does not create a reporting obligation for Victoria Police.

When a person is considered to no longer require a mental health and wellbeing service, the lawful basis of the restrictive intervention under the Act has ended. It is no longer reportable to the Chief Psychiatrist.

Compliance requirements in an ED or UCC

Restrictive interventions on people receiving a mental health and wellbeing service in an ED or UCC of a designated mental health service are subject to the same regulations and oversight under the Act as other parts of a designated mental health service.

To meet their legal obligations, staff in EDs and UCCs must follow specific requirements under the Act relating to authorisation, monitoring, clinical documentation and data entry when restrictive interventions are used. Staff must also give proper consideration to mental health and decision-making principles defined in the Act. These requirements, and related best practice expectations, are outlined in the relevant sections of this guideline.

Seclusion is not a permitted restrictive intervention in EDs and UCCs. The confinement of any person alone in an enclosed space, such as a Behaviour Assessment Room (BAR), without a means of exit is not permitted.

Things to consider before using a restrictive intervention

This section outlines the legal requirements and best practice recommendations that apply before using a restrictive intervention.

Legal requirements

Mental health and wellbeing service providers must aim to reduce and eventually eliminate restrictive interventions (s 125). This objective must be at the centre of all clinical decision making where restrictive interventions are contemplated. The considerations outlined below support this process, providing the basis for informed decision making before using restrictive interventions so they are lawful and a last resort.

For restrictive interventions to be governed under Part 3.7 of the Act, the requirements of s 126 must be met. That is, the person must be receiving a mental health and wellbeing service in a designated mental health service (s 126(1)) or, in relation to the use of chemical restraint during transport, the person is being transported to or from a designated mental health service or any other place under Parts 5.2 and 5.3 in keeping with s 139 (s 126 (2)).

It should also be noted that the use of bodily restraint by an authorised person on a person taken into care and control under Part 5.2 or Part 5.3 is governed under Part 5.6 of the Act.

If a restrictive practice occurs outside of these settings, it is not done under the Act and does not come under the jurisdiction of the Chief Psychiatrist.

Where are restrictive interventions regulated?

Part 3.7 of the Act regulates the use of restrictive interventions (bodily restraint, chemical restraint and seclusion) on a person receiving mental health and wellbeing services in a designated mental health service.

Some examples of settings in which a person is receiving mental health and wellbeing services in a designated mental health service are:

- mental health inpatient units in a designated mental health service
- secure extended care units operated by a designated mental health service
- medical and surgical inpatient facilities of a designated mental health service whenever concurrent medical and mental health treatment, care and support is being provided (typically the role of consultation/liaison psychiatry services)
- EDs and UCCs of designated mental health services (see above).

When can restrictive interventions be used?

Restrictive interventions may *only* be used in respect of a person:

- to prevent imminent and serious harm to that person or another person (s 127 (a)), or
- to administer treatment (as defined in s 5) or medical treatment to the person (s 127(b))
- if necessary to achieve the purposes specified in s 127 (s 128(a)), and
- if all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable (s 128(b)).

The decision to use a restrictive intervention must be made in line with the mental health and wellbeing principles and decision-making principles noted above.

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

Consumers' personal views on the possibility of harm occurring should also be considered in the overall judgement. Families, carers and supporters of the consumer, including any nominated support person, should be supported in their role in such decisions (refer to Box 2).

Box 2: Communication with consumers and their supporters

There are particular requirements in the Act around communication with consumers and others, such as family, a carer, a guardian, a nominated support person or support person and a complainant. Section 7 stipulates that reasonable steps must be taken to provide appropriate supports and to explain the content of the communication and answer any questions as clearly and as completely as possible, and to determine what appropriate supports would assist the person to communicate.

Every designated mental health service has a responsibility to ensure all reasonable efforts are made to give effect to a patient's advance statement of preferences to guide treatment, care and support (s 33).

When are restrictive interventions not permitted?

Restrictive interventions must not be used on a person receiving mental health and wellbeing services in a designated mental health service other than in keeping with the Act. This applies to all people regardless of age or legal status.

The names of Victoria's designated mental health services are listed in the definition in the Act and in Schedule 1 of the regulations. The designated mental health services may provide treatment and care in hospitals, mental health inpatient settings, community mental health settings, EDs and UCCs and in specialist mental health settings for children, adolescents and older adults.

Chemical restraint may be used on a person who is being transported in line with s 139, so long as the requirements in Divisions 1 and 3 of Part 3.7 of the Act are complied with (s 126(2)).

It should be noted that an authorised person using bodily restraint on a person taken into care and control under Parts 5.2 or 5.3 of the Act is regulated under a different part of the Act (Pt 5.6).

The *Charter of Human Rights and Responsibilities Act 2006* and the *Equal Opportunity Act 2010* outline fundamental legal rights of people and should also inform any decision to use, or prevent the use of, a restrictive intervention.

Considerations if authorising a restrictive intervention (s 131)

In determining under s 128 (2) whether there is no less restrictive option available, a person authorising a restrictive intervention should consider the effectiveness of alternative strategies (for example, Safewards interventions) in reducing the likelihood of imminent and serious harm.

The person authorising must, to the greatest extent possible in the circumstances, consider:

- the likely impact on the person, considering their views and preferences, and any relevant past experience of trauma
- the person's views of, and preferences relating to, the use of restrictive practices
- the person's culture, beliefs, values and personal characteristics
- avoiding undue pressure and coercion.

The person authorising the restrictive intervention must consider:

- the views and preferences expressed in any advance statement of preferences of the person
- the views of any nominated support person of the person.

If the person does not have a nominated support person, they should be given the option of choosing a nominated support person.

Advance statements of preferences

Part 2.5 of the Act allows for advance statements of preferences. These set out a person's preferences about their treatment, care and support in the event they become a 'patient'.

There are sections of the Act that govern both how an advance statement of preferences can be made (s 59), revoked (s 60) and changed (s 61) by making a new statement of preferences. The advance statement of preferences may include strategies for avoiding the use of restrictive interventions. They may also include preferences about what should occur if a restrictive intervention is required.

Advance statements of preferences are a significant strategy in reducing the possible use of restrictive interventions. Consumers should be asked whether they have made an advance statement of preferences and the CMI-ODS checked to see if one exists. This applies across the breadth of the designated mental health service. If one does not exist, the option of developing one should be given, particularly in an inpatient mental health setting. This collaboration may help to support the person in feeling safe and empowered. When supported, it can help to build trust and reduce trauma.

How restrictive interventions are authorised

Seclusion or bodily restraint must be authorised by an authorised psychiatrist, or if an authorised psychiatrist is not reasonably available, a registered medical practitioner or a nurse in charge (s 132(1)(a) and (b)). Chemical restraint must be authorised by an authorised psychiatrist or, if an authorised psychiatrist is not reasonably available, a registered medical practitioner or a nurse practitioner acting within their ordinary scope of practice (s 132(2)).

An authorised psychiatrist, registered medical practitioner, nurse in charge or a nurse practitioner acting within their ordinary scope of practice (as the case requires) may authorise the use of a restrictive intervention on a person only if satisfied that it is necessary to achieve a purpose set out in s 127 (s 132(3)).

The registered medical practitioner in an ED is likely to be an emergency medicine consultant or registrar; in a UCC they may be a general practitioner. Despite not being mental health specialists, these staff are expected to familiarise themselves with their obligations under the Act.

A registered nurse may only authorise physical restraint on a person if an authorised psychiatrist, registered medical practitioner or nurse in charge is not immediately available to authorise the use of physical restraint and the registered nurse is satisfied that using physical restraint is necessary to prevent imminent and serious harm to that person or another person (s 132(4)). For the purposes of

determining whether the use of bodily restraint is necessary to prevent imminent and serious harm to that person or another person, a registered nurse does not need to consider the matters set out in s 131 (s 132(5)).

A registered nurse who authorises physical restraint under subsection 4 must notify the authorised psychiatrist, a registered medical practitioner or a nurse in charge about the use of a restrictive intervention as soon as practicable (s 132(6)).[1] If the physical restraint is continuing at the time an authorised psychiatrist, registered medical practitioner or nurse in charge receives a notification from a registered nurse under s 132(6), the authorised psychiatrist, registered medical practitioner or nurse in charge must either authorise the continued use of physical restraint or refuse to authorise the continued use of physical restraint and release the person from restraint (s 132(7)).

If the person who authorises a restrictive intervention is not an authorised psychiatrist, the person must notify the authorised psychiatrist of the authorisation as soon as practicable after it is authorised unless a notification under s 132(6) has been made (s 134(2)).

Best practice

Engagement with consumers and carers

Restrictive interventions must be prevented wherever possible. The Safewards model, and its associated measures for reducing conflict and creating a sense of safety and mutual support between staff and patients, serves as a practical resource for preventing situations that lead to relying on restrictive practices. The publications of consumer and carer peak bodies also offer guidance, outlining steps that can be taken to nurture a therapeutic environment and supportive interactions so a restrictive intervention becomes less likely (see the 'Related guidelines and resources' section at end of this guideline).

The use of restrictive practices needs to adopt trauma-informed care principles to the greatest extent possible. These principles include creating safety, promoting trust and healing, empowering choice and collaboration in decision making.

Any decision to use a restrictive practice must not be unduly influenced by a previous presentation to an ED. It must instead be based on the specifics of each presentation. This does not mitigate the need to read the clinical file, gather collateral information and seek an understanding of possible contributing factors to the situation. For example, a consumer's previous forensic history should not lead to the pre-emptive use of a restrictive practice as a precaution. Service providers must make all reasonable efforts to comply with the mental health and wellbeing principles and give proper consideration to these when making a decision.

Services should consider how the environment in which an assessment takes place may provoke particular responses from both the person and staff involved. For example, being seen in a room where mechanical restraints are on display may precipitate the emotion of fear and a fight-or-flight response.

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[1] The word 'practicable' is not defined in the Act. It has its natural and ordinary meaning of 'capable of being put into practice, done or effected, especially with the available means or with reason or prudence; feasible'. Refer to *Wright v Western Australia* (2010) 203 A Crim R 339 [26], [148] <https://jade.io/article/202823>. There is detailed judicial consideration of the phrase 'as soon as practicable' in *Werden v Legal Services Board* [2012] VSCA 278; 36 VR 637.

Experiences of trauma are common among consumers, family, carers and supporters. Restrictive practices themselves may be experienced as a traumatic event or may precipitate memories of previous traumatic experiences. Responses may vary between people.

Aboriginal people may perceive or be affected by restrictive interventions differently depending on their personal experience of intergenerational trauma, discrimination, colonisation and connection to Country.

Restrictive practices may be more traumatic and potentially more dangerous for people who cannot understand or interpret what is happening due to their cultural, linguistic or migration background. These people may have difficulty communicating questions or concerns due to language barriers. An asylum seeker or refugee's response to restrictive practices may also be influenced by traumatic experiences involving abuse and torture before their arrival to Australia.

People with sensory impairment may not fully understand what is happening or be able to communicate their questions or concerns. Specific interventions, such as physical restraint of an auditory impaired person's hands, may also prevent effective communication.

Staff also need to understand and respond meaningfully to any communications, in whatever form, coming from the consumer during restraint to avoid further trauma and harm to the person. This may inform a decision to end the restrictive practice.

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

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 using 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 with gender sensitivity and the needs and preferences of the consumer in mind. Needs that are not met may add to a person's distress and experience of a lack of dignity, consequently extending the duration of the restrictive intervention and unnecessarily increase associated harms.

Consider the possibility of pregnancy, with an assessment undertaken of the implications of bodily restraint and potential risks of psychological and physical harm. Also consider contraindications in pregnancy and breastfeeding before administering chemical restraint.

Restrictive practices may be particularly traumatic for those with experience of family violence.

It is important to remember that a key part of providing gender-sensitive care is to understand trauma and how it manifests in people when they are in acute distress, recognising that the response to trauma may be different for each person. A trauma-informed response is therefore essential.

Advance statements of preferences and safety plans should be used to ensure care is trauma-informed. Advance statements and safety plans may include a consumer's preferences on to how to best approach them in situations of extreme distress. Families, carers, supporters and nominated support persons can provide valuable and useful insights to assist mental health and wellbeing staff in this regard.

Every effort must be made to routinely provide information sensitively to consumers and carers about the use of restrictive practices and to create an environment of psychological safety such that consumers, carers, families and supporters, including any nominated support person, feel safe to speak up, ask questions and express preferences.

Psychological safety is enhanced by mitigating threats, shame and blame associated with restrictive practices. Reflective practice following restrictive practices can support learning and continuous improvement in the quality and safety of treatment, care and support. It is important for staff to listen, show understanding and respond to consumer and carer concerns about restrictive practices, without judgement.

Aboriginal cultural advisors should be used, wherever possible, to minimise the potential for miscommunication and misunderstanding and to optimise culturally safe and appropriate treatment, care and support. It is important to be aware that communication problems, together with a lack of cultural safety and unconscious bias, may lead to unnecessary restrictive practices and harms to the consumer.

Although it is appropriate to provide information about these practices to families, carers and supporters, including a nominated support person, in general terms, it is only where the consumer consents to disclosing specific planning involving the potential use of a restrictive intervention that the details can be discussed with families, carers and supporters, including a nominated support person. However, when the use of a restrictive intervention has been witnessed by families, carers and supporters, including a nominated support person, or will have implications on the care relationship, it may be necessary to provide more detailed information and specific support.

A service provider is bound by the Act to not share personal or health information about a person in their care if there is a risk that the person will be subjected to family violence or other serious harm (s 31).

A clinician should not assume what a person will experience as a more or less restrictive practice. The hierarchy from less to more restriction is not as linear as chemical restraint being the least restrictive, via bodily restraint including mechanical restraint through to seclusion as the most restrictive. Where possible, particularly if a consumer or patient has experienced a restrictive practice in the past, clinicians are expected to work with the person to incorporate what was learned into a plan (refer below for details).

For practical guidance on avoiding restrictive practices, refer to *Safewards* <https://www.health.vic.gov.au/practice-and-service-quality/safewards-victoria> and *The six core strategies service review tool* <https://www.tepou.co.nz/initiatives/least-restrictive-practice/the-six-core-strategies-service-review-tool>.

Further practical guidance on avoiding restrictive practices can be found in the Safer Care Victoria clinical guideline on caring for people displaying acute behavioural disturbance <https://www.safercare.vic.gov.au/clinical-guidance/emergency/acute-behavioural-disturbance>.

Use of medication

Proper consideration must be given to the mental health and wellbeing principles and, where applicable, the decision-making principles before prescribing medication. Using psychotropic medications to alleviate symptoms of mental illness and to reduce distress is a powerful tool available to clinicians. Although the term 'therapeutic' is not defined in the Act, these medications are intended to be used in helpful ways by clinical mental health services. When used for established indications, with the person receiving them having been informed of the name, purpose, dose, expected effects and side effects, expected time to onset of the effect and the duration of the effect, then the scene for informed consent and informed dissent (the informed decision to decline use of the medication) can be considered to have been set. Providing medication may help to avoid the likelihood of more restrictive practices, including that of chemical restraint.

Potential reasons why a consumer appears to be agitated should be explored and alleviated where possible before progressing to administering medication, particularly a medication with sedating properties. Where possible, oral and short-acting medications should be considered, supporting the person in the decision-making process to the greatest extent possible. The initiation or continuation of non-pharmacological calming strategies (de-escalation) alongside any medication administration may be effective.

A person's advance statement of preferences may reference use of medication, and this information should be used.

Clinicians should also have a good working knowledge of the limitations of medications and be particularly aware of contraindications or a previous history of paradoxical reactions in people.

Services will often have developed 'acute arousal', 'rapid tranquillisation' (or words synonymous with these terms) protocols or guidelines, and where available, clinicians should refer to them.

Two such guidelines that could be used in developing local protocols and guidelines are the Royal Children's Hospital guideline *Acute behavioural disturbance: acute management* <https://www.rch.org.au/clinicalguide/guideline_index/Acute_behavioural_disturbance__Acute_management/> and the Safer Care Victoria clinical guideline on caring for people displaying acute behavioural disturbance <https://www.safercare.vic.gov.au/clinical-guidance/emergency/acute-behavioural-disturbance>.

Nursing care planning

A collaborative nursing care plan that describes the practices that are most effective for the person should be in place. The plan should consider the person's needs, preferences and experiences, as well as the views of their family, carers and supporters, including any nominated support person. This should include a consumer consultant or peer worker if the person approves their involvement. The role of lived and living experience workers should be explained to the person before starting the care plan.

In some services the safety needs of the person 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 person. In an emergency, the opportunity to plan will be more limited. Nevertheless, a plan should be developed as soon as possible.

It is unlikely that a care plan would include the intention to use a restrictive intervention as part of the admission process. A person should be asked if they have had restrictive practices applied to them. Staff can also review case notes for information about the previous use of restrictive practices.

If there is a history of restrictive practices, the person should be asked what, if anything, was helpful, what may have been harmful and what alternative approaches are preferred. These details are then to be incorporated into their safety plan or integrated care plan. The person should be reassured that this conversation is intended to reduce and, where possible, eliminate the use of restrictive practices.

Restrictive practices must only be used as a contingency after all possible less restrictive options have been tried and found to be unsuitable. If restrictive practices are planned, care planning must be undertaken to include:

- the relevant criteria under the Act including the purposes specified in s 127
- all reasonable and less restrictive practices to be tried and considered beforehand (s 128)

- strategies to inform the person compassionately of the decision for the restrictive intervention including why this decision has been made and how the person will be observed, monitored and reviewed.

Consult the person, where possible in the circumstances, on their view of having the restrictive intervention applied to them, including giving them an opportunity to negotiate a different solution if practical. Advance statements of preferences must be considered in care planning, and the views of families, carers and supporters, including any nominated support person, should also be considered.

Staff training and education

Services must ensure there are registered nurses, registered medical practitioners and security staff available who are trained in using restrictive practices. It is recommended that training is developed and delivered through an interdisciplinary approach that includes lived experience expertise. Training should occur with new staff at orientation and all staff through refresher courses to ensure familiarity with the practices.

Training requirements vary across disciplines, depending on their functions and roles. The training programs that services adopt should accommodate and reflect this disciplinary variation.

Training should develop the following clinical knowledge and skills:

- an understanding that the nature and duration of restrictive practices may be reduced or prevented when working within a framework that is trauma-informed, strengths-focused and recovery-oriented
- proficiency in the use of evidence-based preventative strategies to create psychological safety (such as calming methods, usually referred to as de-escalation techniques, and the use of sensory modulation) to ensure restrictive practices are prevented where possible (using the 'six core strategies' and Safewards preventative measures is recommended – refer above)
- awareness that using restrictive practices may cause distress to those who use or witness them, including carers, as well as those to whom they are directly applied
- knowledge of the diverse perspectives on restrictive practices of Aboriginal people, culturally and linguistically diverse people, LGBTIQA+ people and those with an experience of torture, family violence, complex trauma or other experiences of violence and oppression
- an understanding of the causes of aggressive or threatening behaviour and knowledge to address underlying causes – ensure staff are aware of the variety of worldviews of people experiencing psychosis, intoxication or withdrawal and respond in a safe, supportive and non-stigmatising way
- understanding of the new health-needs principle (s 22), which will operate to ensure people who use alcohol and other drugs (including illicit drugs) are not precluded from accessing mental health services – all staff who engage with consumers who use alcohol and other drugs and their families, carers and supporters have a responsibility to identify consumers' needs and provide care that is free from stigma and discrimination
- proficiency in undertaking observation and monitoring requirements
- awareness that people who are unwell can be emotionally and psychologically impacted by conversations and practices that occur during restrictive practices and can remember and reflect on these when well (additional support may be needed to re-establish mental health and wellbeing following a restrictive practice)

- an understanding of the use of and potential for harm associated with restraints – this needs to include proficiency in recognising and compassionately responding to signs of emotional, psychological and physical distress and reducing potential harm
- proficiency in working respectfully with families, carers and supporters, including nominated support persons
- proficiency in responding to escalating emergency responses and basic life support skills including cardiopulmonary resuscitation (CPR)
- an understanding of the standards set out in this guideline, and local policies and procedures.

Health services should ensure executive oversight of all restraint practice and policy development.

Things to consider while using a restrictive intervention

This section outlines the legal requirements and best practice recommendations that apply to a designated mental health service using restrictive interventions.

Legal requirements

There are specific legal requirements that must be followed while using a restrictive intervention.

Authorising

An authorised psychiatrist, or delegate, who authorises the use of a restrictive intervention must examine the person as soon as is practicable to determine if continuing to use the restrictive intervention is necessary to achieve a purpose set out in s 127 (s 134(1)). 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 person who authorises the restrictive intervention is not an authorised psychiatrist, the person must notify the authorised psychiatrist of the authorisation as soon as practicable after it is authorised (s 134(2)). **What is practicable will be determined on a service-by-service basis because this is resource-dependent.** Once the authorised psychiatrist receives this notification, they must examine the person as soon as is practicable to determine if continuing to use the restrictive intervention is necessary to achieve a purpose set out in s 127 (s 134(3)).

If the authorised psychiatrist is not reasonably available to examine the person, the authorised psychiatrist must arrange for a registered medical practitioner to examine the person as soon as practicable to decide whether continuing to use the restrictive intervention is necessary for the purposes outlined in s 127 (s 134(4)).

The authority to use a restrictive intervention ends if a person who may authorise a restrictive intervention is satisfied that using the restrictive intervention is no longer necessary for the purpose for which it was authorised. In this situation, take immediate steps to release the person from the restrictive intervention (s 129).

Notification of the use of a restrictive intervention

As soon as practicable after starting a restrictive intervention on a person, an authorised psychiatrist must take reasonable steps to ensure the following people are notified about the use of the restrictive intervention, the nature of the restrictive intervention and the reason for using it (s 135(2)):

- the person's nominated support person
- a guardian of the person
- a carer of the person (if the authorised psychiatrist believes that using the restrictive intervention will directly affect the carer and the care relationship)
- a parent of the person (if the person is under the age of 16 years)
- the Secretary of the Department of Families, Fairness and Housing (if the Secretary has parental responsibility for the person under a relevant child protection order).

An authorised psychiatrist must also ensure that, as soon as practicable after starting to use a restrictive intervention, the primary non-legal mental health advocacy service provider is notified of its use, the nature of the restrictive intervention and the reason for using it (s 135(3)).

Monitoring the use of restrictive interventions

The term 'monitoring' is used in the Act for a combination of functions including observation, clinical review and examination. A person who is subject to a restrictive intervention must be monitored in accordance with s 137 of the Act. A summary of these monitoring requirements is in Table 1.

Table 1: Summary of monitoring requirements during restrictive interventions with reference to the relevant section of the Act

Restrictive intervention	Requirement	Duration	Frequency	By whom
Bodily restraint (includes mechanical) – s 137(2)(a)	Continuously observe	Ongoing for the entire period of restraint		Registered nurse or registered medical practitioner
Chemical restraint – s 137(2)(b)	Continuously observe	Ongoing for not less than 1 hour after chemical restraint is administered		Registered nurse or registered medical practitioner
Bodily restraint (includes mechanical) – s 137(3)	Clinically review		As often as is appropriate, having regard to the person's condition, but not less frequently than every 15 minutes	Registered nurse or registered medical practitioner
Chemical restraint – s 137(3)	Clinically review		As often as is appropriate, having regard to the person's condition, but not less frequently than every 15 minutes	Registered nurse or registered medical practitioner
Seclusion* – s 137(3)	Clinically review		As often as is appropriate, having regard to the person's condition, but not less frequently than every 15 minutes	Registered nurse or registered medical practitioner
All restrictive interventions – s 137(4)	Examine		As often as is appropriate, having regard to the person's condition, but not less frequently than every 4 hours	Authorised psychiatrist. If not practicable for an authorised psychiatrist to conduct an examination at the frequency that the authorised psychiatrist is satisfied is appropriate, the person may be examined by a registered medical practitioner when directed by the authorised psychiatrist (s 137(5)).

* Seclusion is not permitted in EDs and UCCs.

Continuous observation

A person who authorises the use of a restrictive intervention on a person must (s 137(2)):

- In the case of bodily restraint, including mechanical restraint, ensure the person is continuously observed by a registered nurse or registered medical practitioner for the entire period of the restraint. The Act does not allow for other staff, including security personnel and enrolled nurses, to do the monitoring of any restrictive intervention.
- In the case of chemical restraint, ensure the person is continuously observed by a registered nurse or registered medical practitioner for not less than one hour after the chemical restraint is administered.
- In the case of chemical restraint where the person requires transport, it is not necessary for the designated mental health service to maintain monitoring of the person as required by s137. The person is no longer receiving a mental health and wellbeing service *in* the designated mental health service. Ambulance Victoria is not bound by the monitoring requirements of the Act.

Continuous observation 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 engagement with the person. The engagement may be effective in bringing the restrictive intervention episode to an end.

The requirement for continuous 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 physical safety including their level of consciousness, mental health and wellbeing status, communication needs and dignity.

Continuous observations can involve 2 approaches:

- **Constant arm's-length observations** occur with the person being always in arm's length of a registered nurse or registered medical practitioner.
- **Constant visual observations** occur with the person being always within the vision of a registered nurse or registered medical practitioner.

A collaborative decision about 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. Documentation should include the rationale for the decision about the type of continuous observation. The person being observed should be made aware of the observation type, purpose and duration. Where possible they should be involved in decision making about observations. Some consumers may need or prefer close proximity to another person to reassure/support them while affected by the chemical restraint and/or their original distress.

The observations should include but are not limited to assessing:

- breathing
- level of movement
- alertness and responsiveness
- levels of agitation
- the need to continue the restrictive practice
- status of the consumer, established through direct conversation.

More information is in the *Nursing observation through engagement in psychiatric inpatient care guideline* <https://www.health.vic.gov.au/practice-and-service-quality/nursing-observation-through-engagement-in-psychiatric-inpatient-care>.

While determining the end point of bodily restraint and seclusion is straightforward, it is less so when it comes to chemical restraint. **Other than in the rare instances where someone is receiving and then ceasing the use of intravenous medication, the end point for chemical restraint for the purpose of ceasing, or decreasing the frequency of the observation, must be clinically determined and based on the condition of the person when formal clinical review and/or examination takes place.**

The Chief Psychiatrist is aware that there may be instances where the restrictive practices of both chemical restraint and seclusion co-occur. This is not encouraged because this type of practice is known to contribute to deaths. Efforts must be made to comply with the requirement of continuous observation in this circumstance. On rare occasions, the purposeful gathering of information may need to be by other means – for example, by what is heard occurring in the seclusion room, rather than what is directly observed, given that continuously observing someone through a seclusion window may be highly provocative for them. CCTV is not to be used as a substitute for nursing or clinical observation. Where the requirement for continuous observation by constant visual observation is not met, it must be recorded and reported to the Chief Psychiatrist as a breach of the Act.

Should the practices of chemical and mechanical restraint co-occur, both have the requirement of continuous observation. If mechanical restraint is ceased, there is still the requirement for continuous observation for the minimum one-hour after administering the last medication given for this purpose.

The Chief Psychiatrist has become aware of instances where the term 'a break in seclusion' is being conflated with the cessation of seclusion. Opening the seclusion room door to enter for the purposes of a clinical review or an examination as described below, or to allow bathroom use for toileting and hygiene purposes to preserve some dignity for the person, is not the same as a clinical decision to end seclusion.

Clinical review

A registered nurse or registered medical practitioner must clinically review a person subject to a restrictive intervention as often as is clinically appropriate, having regard to the person's condition, but not less frequently than every 15 minutes (s 137(3)).

A clinical review is required during bodily restraint (physical and mechanical), chemical restraint and seclusion (s 137(3)), as outlined in Table 1 above.

A clinical review 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:

- alertness and responsiveness
- levels of agitation and distress
- movement
- breathing
- neurovascular observations of the restrained limb(s) (pulse, colour, warmth, sensation, movement and the experience of pain)
- pulse
- temperature
- skin integrity

- hydration, nutrition and elimination needs.

Clinical reviews should also include monitoring the impacts of alcohol and other drug withdrawal and/or intoxication. Withdrawal management prevents unnecessary physical and emotional harm and distress to the person. This monitoring should include direct communication with the person to establish their subjective experience of withdrawal, and access to appropriate pharmacotherapy or symptom management medications as required, as per the withdrawal guidelines. Timely intervention for withdrawal symptoms prevents significant adverse events such as pain, seizures and death.

Examination

An authorised psychiatrist must examine a person subject to a restrictive intervention as often as the authorised psychiatrist is satisfied is appropriate in the circumstances to do so, but not less frequently than every 4 hours (s 137(4)).

If it is not practicable for an authorised psychiatrist to conduct an examination at the frequency that the authorised psychiatrist is satisfied is appropriate, the person must be examined by a registered medical practitioner when directed by the authorised psychiatrist (s 137(5)).

Each examination should be as thorough as the circumstances permit. It 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. When carrying out this assessment, try to obtain the direct input of the person.

The **'Restrictive interventions observation form' (MHWA 142)** needs to be completed to maintain a record of clinical observations or reviews. This form must be completed by the registered nurse or registered medical practitioner undertaking the observations or reviews. A form must be completed to record the type of restrictive intervention, the date and time that each type of restrictive intervention starts and ends, and the detail of the observations or reviews. This includes recording any significant conversation details with the person affecting their need either for the ongoing restrictive practice (particularly seclusion and mechanical restraint) or indicating that the person is suitable for release (refer to the 'Clinical documentation' section below for details).

For more on this and other reporting processes related to restrictive interventions, refer to the *Chief Psychiatrist's reporting directive for restrictive interventions* <https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions>.

Meeting the needs of the person

The clinician who authorises a restrictive intervention must ensure the person's needs are met and that the person's dignity is maintained by providing appropriate facilities and supplies (s 136(1)). This can be done through the following actions:

- Consider the person's views and preferences and any relevant experience of trauma, their preferences for restrictive interventions and their culture, beliefs, values and personal characteristics including language, age, disability, religion, gender, sexuality, trauma history and vulnerabilities.
- Consider the person's advance statement of preferences and the views of any nominated support person.
- Throughout restrictive practices the person should be given a clear explanation of the process they are being subjected to. Check the person's understanding and create the opportunity for questions and concerns to be raised. Provide reassurance to help limit distress and fear.

- Protect the person's dignity. Ensure trauma-informed practices are at the forefront of interactions.
- Check that body positioning is safe, comfortable and appropriate and that the airway is unrestricted.
- Review the person's vital signs and escalate concerns in a timely manner.
- Prevent adverse effects such as pressure sores, abrasions, tissue damage, injury from immobilisation and the effects of withdrawal and seizures.
- Ensure the person's hydration and nutritional needs are met. Start a fluid balance chart for the person subject to the restrictive intervention.
- Establish if the person is a smoker and provide adequate nicotine replacement therapies to reduce withdrawal symptoms and cravings.
- Provide adequate arrangements and assistance for elimination needs and personal hygiene including clean clothing, bedding, toilet paper, a gender-appropriate urinal or bed pan and sanitary products as required. Make all attempts to maintain the person's dignity and privacy during toileting and washing.
- Provide the opportunity for physical exercise as appropriate.
- Ensure the person's clothing is comfortable, appropriate and considers the person's preferences, and that it maintains dignity.
- Negotiate removing potentially dangerous items in a respectful manner and store the items appropriately.
- Ensure the prescription and administration of medications. Someone in alcohol or opioid withdrawal may present as agitated or anxious and be viewed as aggressive, possibly leading to an escalation of restrictive interventions. The correct withdrawal medication must be charted to minimise the risk of the adverse effects of alcohol or opioid withdrawal, including seizures and extreme psychological distress. If symptoms of withdrawal from alcohol and other substances are not effectively managed, this may lead to avoidable use or escalation of restrictive interventions.
- Nursing staff should also be aware of the need for the person to have contact with family, friends, carers or supporters, and any nominated support person, to help reduce the trauma of the experience. Other supports include peer support workers, lived and living experience workers, Aboriginal health liaison officers and Koorie mental health liaison officers. In particular, the carer of a young person must be informed of the use of a restrictive intervention as soon as possible. For people with physical disabilities, equipment that provides support, such as hearing aids, must be implemented as soon as appropriate. Similarly, for culturally and linguistically diverse people with limited or no English proficiency, access to an accredited interpreter must be offered to enable effective communication.
- Continue with Safewards and other actions including soft words, treating the person with genuine respect and expressing warmth and understanding for them. Empathise with the person and be compassionate. Be aware that they are experiencing a difficult time in their life. It is important to listen and acknowledge their expression of their experiences at the time, even if interpreted as delusional or a symptom of mental illness. This will help reduce their fear. Avoid dismissing what is important to them in that moment.
- Where communication is established with the person, any requests or needs identified should be responded to and addressed as soon as practicable. Where needs and requests cannot be addressed immediately, a timeline for action or a reason for denial should be given.

Best practice

Restrictive intervention techniques

The different types of restrictive interventions are defined in the 'Key definitions' section of this guideline.

In considering **seclusion**:

- A person may be kept in seclusion only if it is necessary to prevent imminent and serious harm to themselves or others.
- Seclusion must not occur in behavioural assessment rooms in EDs/UCCs or in rooms within the general hospital. These settings are not designed for using and monitoring seclusion as required by the Act.
- Seclusion can only be undertaken in purpose-built and designated seclusion rooms in acute inpatient, forensic and secure mental health units.
- Authorisation (s 132) and monitoring (s 137) of seclusion must occur in line with the Act.

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 safe.
- Physical restraint techniques that apply direct pressure to the neck, thorax, abdomen, back or pelvic area 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 nurse in charge or registered medical practitioner as defined by the health service's procedures needs to assume responsibility for leading the team through the restraint process in line with the Act, ensuring the person's 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. Sincere efforts should be made to maintain the person's dignity.
- If the floor is used, then this should be for the shortest period and for the purpose of gaining control of the situation.
- Prone (face-down) restraint poses a risk of serious injury and should not be used unless absolutely unavoidable (refer to Box 3).
- If prone restraint is used, a registered nurse or medical practitioner will ensure the person is not in a prone position for longer than 3 minutes.
- There is no completely safe time limit for any physical restraint technique. Physical restraint must end as soon as possible.
- If the person experiences pain or voices distress during physical restraint, the technique should be altered immediately to achieve a pain-free experience.
- All staff involved in restrictive interventions should be educated in using restraint and the risks associated with restraints.

Box 3: Prone restraint

Prone restraint is a form of bodily restraint regulated under the Act. Prone restraint (the act of placing a person so they are lying on their front, face-down) is a significant risk to a person's safety. As such, prone restraint is to be avoided.

If a person is put in a prone position during a restraint, this must end as soon as practicable and is not to exceed 3 minutes. If prone restraint continues for longer than 3 minutes, this is to be documented and reported to the Chief Psychiatrist. Allow the person to be in a less restrictive position before engaging them in conversation to reduce distress and preserve their dignity.

The physiology of restraint-related deaths is difficult to determine because classifications of deaths vary from place to place. Factors include:

- the position a person is held in, particularly the prone position
- acute behavioural disturbance and agitated delirium
- stress-related cardiomyopathy
- alcohol and drug use.

A review by Duxbury and colleagues found that out of 38 restraint-related deaths over 21 years, 26 deaths were associated with positional asphyxia.[2] Positional asphyxia occurs when a person being restrained is placed in a position that compromises their breathing and, as a result, the person does not get enough oxygen. When there is a lack of oxygen, disturbance in cardiac rhythm may occur and result in death.

It is recommended that a registered nurse is responsible for monitoring vital signs and ensuring the chest and neck area of a person is not compressed. It is safer to position the person face-up rather than face-down. This should occur instead of the prone position whenever possible. Staff using prone restraint are to communicate with the person in a reassuring way to explain the process, both before and during the restrictive intervention. Nursing staff are to respond to the person and any voicing of distress. Any indication that the person cannot breathe is to be taken very seriously and immediate action is required. Where completely unavoidable, the prone restraint is to be for minimum time and with minimum force. Care should be taken with the person's position to ensure the airway is kept clear and the upper body is not compressed.

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.
- Items such as sheets and blankets (may be known as a blanket wrap in some services) should not be used as mechanical restraint devices, and if they are, this should be recorded as using mechanical restraint and reported to the Chief Psychiatrist as a breach <https://www.health.vic.gov.au/chief-psychiatrist/reporting-a-failure-to-comply-with-the-mental-health-and-wellbeing-act-2022> on all occasions.

[2] Duxbury J, Aiken F, Dale C (2011) 'Deaths in custody: the role of restraint', *Journal of Learning Disabilities and Offending Behaviour* 2.4: 178–189.

- The device must be applied for the minimum time required. Releasing the person's 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.

In considering **chemical restraint**:

- Chemical restraint must not be used on a person who is being transported, other than in line with Divisions 1 and 3 of Part 3.7 of the Act.
- Under s 139 a registered medical practitioner may only use chemical restraint if they are satisfied it is necessary to prevent imminent and serious harm to the person being transported or another person.
- A registered medical practitioner may also direct a specified person (detailed in s 139(3)) to use chemical restraint on the person being transported if they are satisfied it is necessary to prevent imminent and serious harm to that person or another person.
- Before using chemical restraint or continuing chemical restraint, the cognitive effects of the medication should be considered and whether this will have a negative impact on the person's ability to self-manage their current symptoms. Attempts should be made to gather this information directly from the person.

Known adverse events associated with using 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 associated with the loss of dignity and autonomy; acute stress reactions and possibly of developing post-traumatic stress disorder (PTSD).

The use of restrictive practices is clinically led. Restrictive practices should never be used as a punishment. Security staff involved in using a restrictive practice must act as directed by the nurse in charge (in relation to bodily restraint), nurse practitioner (in relation to chemical restraint), authorised psychiatrist 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 manager responsible for the service.

A medical review of the person must take place after the restrictive practice has ended.

At an appropriate time for the person after the restrictive intervention, a debriefing should occur to help the person process their experience and identify lessons learned for reducing the likelihood of a restrictive practice being used again or altering aspects of future restrictive practices.

For more, refer to the *Nursing observation through engagement in psychiatric inpatient care guideline* <https://www.health.vic.gov.au/practice-and-service-quality/nursing-observation-through-engagement-in-psychiatric-inpatient-care>.

Medical assessment

If the restrictive intervention was authorised by a registered practitioner, nurse in charge or nurse practitioner acting within their scope of practice, the authorised psychiatrist is to examine the person as soon as practicable after being notified (s 134). **What is practicable will be determined on a service-by-service basis because this is resource-dependent.**

When restrictive practices have been applied to prevent potential serious and imminent harm, a medical examination must be conducted as soon as practicable after the restrictive intervention has begun. This should include identifying and documenting any alcohol and other substance use, recent medical procedures, surgical procedures or health conditions. Clinically significant signs, or a cluster of symptoms of possible intoxication or substance use, should be considered when monitoring a person's medical status. Lack of coordination, impairment in attention/memory and slurred speech may suggest intoxication or substance use and require frequent medical monitoring. Clinically significant signs or a cluster of withdrawal symptoms should be considered and include psychosis, agitation, physical distress, complaints of pain, seizures and delirium. Failure to effectively manage and monitor for signs of withdrawal may result in highly adverse outcomes, including death.

A person may be unwell, unwilling to respond to questions in a way that can be readily understood or use expletive-laden language that may be difficult to tolerate, and all of these will impair effective communication. Communication may be further impaired when restrictive interventions that are highly distressing and disempowering are in place. These factors may affect the sense of safety both for the person and the medical practitioner. The 'best possible' medical assessment must take place under these circumstances.

Communication

Information about the restrictive intervention must be provided to the person at the time the intervention is used. This includes talking to the person through the stages of the restrictive intervention, providing explanations and reassuring them. Consider involving a consumer consultant, peer support worker or Aboriginal health liaison officer / Koorie mental health liaison officer.

Staff must offer information on restrictive practices to visitors and to other people (including other consumers) who have witnessed a restrictive intervention and provide an opportunity to discuss any concerns they may have from witnessing it. The privacy and confidentiality of those involved should always be maintained. Because restrictive practices are not therapeutic, it is important to recognise that they are potentially traumatising to a variety of people, including the person, witnesses, staff, carers, family members and supporters. Those who witness or are otherwise affected by the restrictive intervention are to be offered timely, appropriate and individualised support. This may be at the time of the event or if requested later. Peer support workers, lived and living experience workers, Aboriginal health liaison officers / Koorie mental health liaison officers and others involved may need support and this should be offered.

Clinical documentation

The person's clinical record should reflect that the requirements of Part 3.7 of the Act, this guideline and local policies and procedures have been met.

Under s 133 of the Act, the authorised psychiatrist, registered medical practitioner, nurse practitioner, nurse in charge or registered nurse must document the following matters as soon as practicable after authorising the restrictive intervention:

- the reason the restrictive intervention is necessary
- all the other less restrictive means tried or considered for the person in trying to achieve the purpose of the restrictive intervention (for example, administering medication)
- the reasons why those less restrictive means were unsuitable.

The following matters should also be documented on the person's clinical record:

- any attempts made to communicate with the person, listen to and address their requests and consult with or contact their families, carers and supporters and/or nominated support person to avoid using a restrictive intervention
- a description of the person's condition at the start of the intervention
- details arising from the nursing observations and clinical reviews
- any medication or other treatment provided and the response to treatment
- the outcome of the initial and 4-hourly medical examinations
- details of second opinions and/or case conference reviews
- the nursing care plan
- a copy of the completed MHWA 140, 141 or 143 authorisation form
- a copy of the MHWA 142 restrictive interventions observation form
- confirmation relevant people have been notified of the use of the restrictive intervention under ss 134, 135 and 138 (as listed in the notes section of the MHWA forms 140, 141 and 143 under 'Notifications')
- correct contact details, including a phone number that will enable access to the opt-out non-legal advocacy service provided by IMHA
- post-intervention support that was considered and/or provided that meets the needs and preferences of the person
- debriefing that took place with the person, any lessons learned and planned updates to the nursing care plan or advance statement of preferences (if relevant)
- the person's interpretation of what happened and why.

Things to consider after using a restrictive intervention

This section outlines the legal requirements and best practice recommendations that apply after using a restrictive intervention.

Legal requirements

There are specific legal requirements that must be followed after using restrictive interventions.

Release from restrictive interventions

If a clinician who can authorise a restrictive intervention is satisfied that the restrictive intervention is no longer necessary, they must take immediate steps to release the person from the restrictive intervention (s. 129(2)).

The authority to use a restrictive intervention under the Act ends if a clinician who may authorise the restrictive intervention is satisfied that the restrictive intervention is no longer necessary for the purpose for which it was authorised (s 129(1)).

If a restrictive intervention needs to be reintroduced, a new period of use begins, requiring a new approval and/or authorisation process.

Review

As soon as practicable after a restrictive intervention ends, the authorised psychiatrist must ensure the restrictive intervention is reviewed (s 138(1)(a)). This review must be completed in a timely manner (s 138(3)).

The person subject to the restricted intervention must be offered an opportunity to review the intervention with the designated mental health service and should be offered the opportunity to have their nominated support person, a mental health advocate, family member, carer or other supporter participate (s 138(1)(b)).

It is possible, if not likely, that the review may need to take place in a different setting and with different personnel than those who were directly involved in the authorising and use of the restrictive intervention – for example, where the restrictive intervention took place in the ED and the person is now on a mental health inpatient unit. Services will need to develop clinical and documentation pathways so they are aware of and can document that the review took place, including following up any identified actions. The review is also an opportunity to inform what may go into an advanced statement of preferences.

Reporting to the Chief Psychiatrist

Designated mental health services must submit to the Chief Psychiatrist restrictive intervention data from the previous month via the Office of the Chief Psychiatrist SharePoint portal <https://dhhsvicgovau.sharepoint.com/sites/OCP> by the 10th of each month.

If there are issues accessing the SharePoint portal, services can email the Office of the Chief Psychiatrist for assistance <ocp@health.vic.gov.au>.

The submitted data must:

- be a scanned copy of the CMI/ODS report (known as registers)
- be signed by the authorised psychiatrist or delegate to confirm that they have reviewed and verified the data
- include registers for seclusion and all forms of bodily restraint (physical and mechanical) and chemical restraint.

For detailed instructions to assist with reporting obligations, refer to the *Chief Psychiatrist's reporting directive for restrictive interventions* <https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions>.

Breaches of the Act and serious adverse events (ISR 1 & 2) must be reported to the Chief Psychiatrist in keeping with the timelines outlined in the Reporting Directive.

Best practice

Post–restrictive intervention consumer support

It is a priority to review the use of a restrictive practice and to plan collaboratively with the person to minimise the future use of restrictive practice. The person's insight, understanding and experience of the incident should be explored. The person must be provided a safe space to ask questions and talk about approaches that can help reduce distress and support self-regulation and self-soothing.

Restrictive practices are commonly experienced as traumatic and so require sensitivity and skill to promote psychological and emotional safety for the person and to encourage a trusting, collaborative, therapeutic relationship with the care team to address trauma and provide healing. The person needs to be empowered to discuss their experience of the restrictive intervention.

The purpose of a post–restrictive intervention support session is to provide an opportunity for the person's experience of the episode to be understood, acknowledged and heard with care and compassion. Attempts to defend and justify the decision to use a restrictive intervention may be counterproductive and are to be avoided. Active listening skills and validating the person's experience are encouraged.

The person should be given a choice about who they 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 separately to other people, as appropriate, including family members, carers and supporters and other patients who witnessed the event, as soon as practicable and within a reasonable time frame.

Staff members should be given an opportunity to reflect and subsequently improve clinical practice both individually and systemically through the feedback provided in these sessions.

Experience of care review

The person who was subject to the restrictive intervention must be offered an opportunity to take part in reviewing the intervention (s 138(1)(b)) and be permitted to choose their nominated support person, and/or their family, carers and supporters, to take part in the review.

Following the restrictive intervention, a formal systemic review must occur as soon as practicable with input from a range of staff including the nurse unit manager, senior registered nurses, a consultant psychiatrist, any other staff involved (such as lived and living experience staff) and carer and consumer consultants from the service concerned.

The aim of the experience of care review is to:

- involve the person, their nominated support person and/or family, carers and supporters in reflecting on the restrictive intervention and for staff to respond to questions and concerns to alleviate any trauma that occurred as a response to the restrictive practice
- involve the person in considering what else might have been done to prevent, minimise or change the use of a restrictive intervention
- review the use of the restrictive intervention in light of the factors that led to its use
- identify preventative strategies trialled to prevent the restrictive intervention and the reasons for the practice failure and consider future responses
- review compliance with the Act
- review system-wide management issues that may need addressing to reduce and, where possible, eliminate use of restrictive practices
- ensure any systemic or safety issues that would usually generate an incident report are appropriately documented and escalated for information and remedial action
- engage mental health clinicians in reflective practice to identify and address possible moral and/or physical injury or trauma and provide pathways to access additional support and training, where needed.

Any systemic issues identified need to be forwarded to the relevant safety and quality improvement committee for attention. Restrictive intervention monitoring and reporting should be included in the designated mental health service's ongoing quality assurance program. Findings from this review should inform training programs and other staff development initiatives. This data should also inform strategy and policy to reduce and, where possible, eliminate restrictive practices.

Other quality-improvement activities should include local clinical audits based on the knowledge and application of Part 3.7 of the Act, local policies and procedures, and this guideline. Box 4 provides guidance on this aspect of health service self-assessment. These are leadership activities to enhance strategies to reduce and, where possible, eliminate the use of restrictive practices.

Box 4: Health service self-assessment of restrictive practices

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 practices are comprehensively reviewed

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

Practice improvements are made by reviewing restrictive practices via the health service Lived and Living Experience–informed clinical governance framework.

Case conferences and second opinions

Where a restrictive practice is used for extended periods or recurrently, it is good clinical practice to convene a case conference. People who repeatedly pose a risk of imminent and serious harm to themselves or others and for whom reasonable and less restrictive options have been tried, considered and found to be ineffective require carefully considered treatment, care and support.

Underlying causes should be thoroughly investigated and addressed. This includes reviewing the person's medical history and relevant pathology results. The medication history must be reviewed to optimise safe, effective, appropriate use of medication and to identify medication that has previously been unhelpful or has been associated with unacceptable side effects or allergies. The impact of other contextual factors such as social, spiritual, cultural and environmental aspects (including people, processes and places in the inpatient unit) should be considered. Contextual factors may be discussed in a case conference with the person, their nominated support person and/or their family, carer and supporters, and a peer worker where possible.

It is good clinical practice to get a second opinion to review the person'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:

- considers the person's views and preferences, including those documented in statements of preferences, if available
- describes the behaviour in question
- identifies the precipitating and exacerbating factors identified by clinicians, the person and their nominated support person and/or their family members, carers and supporters
- outlines strategies that the person finds helpful for reducing precipitating factors and that support self-regulation and self-soothing
- describes a graded series of responses that begin with the least restrictive that are guided by the person's preferences (if restrictive interventions are needed to prevent imminent or serious harm).

Developing local policies and procedures

All services should have local policies and procedures that consider the service setting, populations served and any other relevant local factors. Mechanisms must be set up to facilitate regular reviews of all incidents of restrictive practice. This is to ensure compliance with this guideline and the Act, to promote human rights and dignity, and to minimise trauma. In addition, all services must reduce and ultimately work towards eliminating restrictive practices. Specific considerations should be given to the following. More than one of these considerations may occur together; that is, there are intersectional experiences.

Aboriginal people

Aboriginal people may perceive or interpret the use of a restrictive intervention differently depending on their cultural background and personal experiences due to colonisation and intergenerational trauma.

Further care must be taken to provide culturally safe, effective and appropriate communication to avert the use of the restrictive intervention, if possible, and to minimise the trauma of the intervention to the person, both during and after the intervention. It is important to be aware that communication problems, together with a lack of cultural safety, may lead to unnecessary restrictive practices. Cultural advisors should be used, if possible, to minimise the potential for miscommunication and misunderstanding and to optimise culturally safe and appropriate treatment, care and support.

Children and adolescents

The developmental status, including that of a known or suspected neurodevelopmental condition such as autism spectrum disorder, of a young person must be considered in any decision to use a restrictive intervention. Avoid using any restrictive practice with children under the age of 12 years. Restrictive practices must be used with caution when they involve adolescents because in most cases their musculoskeletal systems are immature, which elevates the risk of injury. Clinicians should be alert to the possibility of sensitivity and paradoxical reactions to psychotropic medications.

The carer of a young person must be informed of the use of a restrictive intervention as soon as practicable. A decision to involve family, carers and supporters in the debriefing process must consider the young person's capacity to consent to their involvement.

Culturally and linguistically diverse people

Restrictive practices may be more traumatic and potentially more dangerous for a person who cannot understand what is happening or cannot communicate their questions or concerns. The person may perceive a restrictive intervention differently depending on their cultural background and personal experiences such as being a refugee or being a survivor of abuse or torture.

Where a person receiving treatment and care has limited or no English language proficiency, service providers must offer access to an accredited interpreter. This obligation applies to treatment and care for people who use Auslan to communicate. Carers of the person should also be offered access to an interpreter when required. Offering a language service satisfies a duty of care. Given this, failure to promote the availability of a language service may have legal consequences for the service provider.

The legal requirements on using language services and guidance on how to work effectively with language services in a healthcare setting can be found in the Victorian Government's *Language services policy* <https://www.health.vic.gov.au/publications/language-services-policy>.

Where culturally and linguistically diverse people are receiving treatment and care, specific attention must be given to establishing effective communication to avert a restrictive intervention, if possible, and to minimise the trauma of the intervention to the person, both during and after the intervention. It is important to be aware that communication problems and a lack of cultural safety may lead to unnecessary restrictive practices. Accredited interpreters should be used (telephone or face-to-face) or cultural advisors and Aboriginal health liaison officers / Koorie mental health liaison officers, if possible, to minimise the potential for miscommunication and misunderstanding and to optimise culturally safe and appropriate treatment, care and support. Communication has successfully occurred when the person understands the information.

If the person is comfortable, carers or family members may be involved in the post–restrictive intervention review. Any post–restrictive intervention review should occur with accredited Auslan or accredited language interpreters and/or translators, as required, ensuring the interpreter understands the person (and vice versa) before starting the review.

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 person's preferences should be sought and responded to. Arrangements for clothing, searches for dangerous objects, toileting and review should also be undertaken regarding gender sensitivity. Consideration should also be given to the possibility of pregnancy in consumers and the implications of this, especially if medications that are contraindicated during pregnancy and subsequent breastfeeding are being considered. The specific needs of LGBTIQA+ consumers should also be considered, focusing on providing respectful and inclusive care.

It is important to remember that a key part of providing gender-sensitive care is to understand trauma and how it manifests in people when they are in acute distress, recognising that the response to trauma may be different for each person. An individualised person-centred response is therefore needed.

Intellectual disability or acquired brain injury

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

It is common for these consumers to need individualised treatment, care and support to alleviate agitation and distress and to help give them a sense of safety and wellbeing. People with cognitive impairment may have diverse needs that require further consideration to minimise the risk of a restrictive intervention. The views of family, carers and supporters, and any nominated support person, may be considered and inform treatment, care and support to minimise and, where possible, eliminate the need for restrictive practices.

It is important, wherever possible, for the nature of the intervention and the reasons for it to be explained in language the person can understand, using any aides that may be required, and as often as is required. Communication has successfully occurred when the person understands the

information, even if only at a rudimentary level. All the above points should be outlined in a detailed care plan.

Older people

Consider the ramifications of using 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 people. In addition, chemical restraint may worsen underlying confusion, cognitive impairment and associated agitation and distress. Further consideration should be given to assessing for underlying or emerging medical conditions affecting the person's mental health, wellbeing and responses to treatment, care and support.

Carers' views may be considered according to the needs and preferences of an older person, together with any advance statement of preferences for a restrictive intervention. Preferences for notification of such events should also be documented in the treatment plan. 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.

People with sensory impairment

A restrictive intervention may also be more traumatic and potentially more dangerous for people who cannot fully understand what is happening or cannot communicate their questions or concerns due to sensory impairment. Specific practices, such as the physical restraint of an auditory-impaired person's hands, may also prevent effective communication.

Further care must be taken in these situations to achieve safe, effective and appropriate treatment, care and support. In these situations, consider engaging carers who are familiar with the communication and wellbeing needs of the person.

Carers and/or family members may be involved in the post–restrictive intervention review if the patient chooses this. Post–restrictive intervention reviews should occur with accredited Auslan or language interpreters and/or translators, as required, ensuring the interpreter understands the person (and vice versa) before starting the review.

Trauma

A history of trauma is relevant to the experience of restrictive practices. This may include some aspects of post-traumatic stress disorder, complex post-traumatic stress disorder, child abuse, asylum seeking and refugee experiences, family violence and Aboriginal social and emotional wellbeing. Prior experience of trauma raises the possibility for new trauma occurring and a reoccurrence and escalation of an already established trauma.

Related guidelines and resources

The guidelines and resources below provide more information on restrictive practices that may be useful to clinicians and consumers.

Government websites and publications

Mental Health and Wellbeing Act 2022 <https://www.legislation.vic.gov.au/as-made/acts/mental-health-and-wellbeing-act-2022>

Chief Psychiatrist's reporting directive for restrictive interventions
<https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions>

Chief Psychiatrist's guidelines <https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrist-guidelines>

Royal Commission into Victoria's Mental Health System final report
<https://finalreport.rcvmhs.vic.gov.au/>

Providing a safe environment for all: Framework for reducing restrictive interventions, 2013
<https://www.health.vic.gov.au/publications/providing-a-safe-environment-for-all-framework-for-reducing-restrictive-interventions>

Reducing restrictive interventions: Literature review and document analysis, 2013
<https://www.health.vic.gov.au/publications/reducing-restrictive-interventions-literature-review-and-document-analysis-2013>

Guidance: Acute behavioural disturbance, Safer Care Victoria
<https://www.safercare.vic.gov.au/clinical-guidance/emergency/acute-behavioural-disturbance >

Acute behavioural disturbance: acute management, Royal Children's Hospital
<https://www.rch.org.au/clinicalguide/guideline_index/Acute_behavioural_disturbance__Acute_management/>

Guidelines on the statutory duty of candour, Safer Care Victoria
<https://www.safercare.vic.gov.au/support-training/adverse-event-review-and-response/duty-of-candour>

Safewards, Safer Care Victoria
<https://www.safercare.vic.gov.au/best-practice-improvement/improvement-projects/mental-health-wellbeing/safewards-victoria-trial>

Other websites and publications

Family care and supporter views on seclusion and restraint, Tandem
<https://tandemcarers.org.au/common/Uploaded%20files/Seclusion_Restraint_Tandem_2023.pdf>

Ending seclusion & restraint, Victorian Mental Illness Awareness Council (VMIAC)
<https://www.vmiac.org.au/research-intro/ending-seclusion-restraint/>

Independent Mental Health Advocacy (IMHA)
<https://www.imha.vic.gov.au/>

Academic publications

Gooding, P. et al (2020) 'Preventing and reducing "coercion" in mental health services: an international scoping review of English-language studies', *Acta Psychiatrica Scandinavica*, 141.2, 1–14. Available at: https://onlinelibrary.wiley.com/doi/full/10.1111/acps.13152.

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Muir-Cochrane, E., et al (2019) 'Prevalence of the use of chemical restraint in the management of challenging behaviours associated with adult mental health conditions: a meta-synthesis'. *Journal of Psychiatric Mental Health Nursing,* 27(4), 1–21. Available at: https://onlinelibrary.wiley.com/doi/abs/10.1111/jpm.12585.

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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 and Wellbeing Act.

The Chief Psychiatrist wishes to thank the various people who helped develop this guideline. Their advice and feedback was invaluable and helped make this guideline stronger.

Appendix: Determining when medication use requires reporting to the Chief Psychiatrist

Purpose of prescribing/use & situation	Medication type & route	Chemical restraint and requires reporting?
Aggressive behaviour endangering others where the intention is to sedate sufficiently to control the person's movement	Ketamine, IM or IV	Yes
Aggressive behaviour endangering others where the intention is to sedate sufficiently to control the person's movement	High-potency, short-acting antipsychotic given IV or IM	Yes
For an acute psychosis and the dose and dose interval are within accepted treatment guidelines; used to good clinical effect without excessive sedation	Zuclopenthixol (Clopixol Acuphase), IM	No
Antipsychotic medication has been initiated to treat a manic illness; the person is attempting to abscond from the ward and threatens to harm staff. The primary purpose of the parenteral benzodiazepine is to control the person's movements	Benzodiazepine, IM	Yes
As a muscle relaxant after seizure activity, for the primary purpose of treating a physical illness	Benzodiazepines orally	No
To treat serious illness and substance dependence. The primary purpose is to treat these conditions and not to control a person's movement	Long-acting injectable antipsychotic and opioid substitution therapy medications	No
Management of substance withdrawal using an established protocol	High-dose benzodiazepine	No