Australian Capital Territory

Mental Health (Use of Restraint) Guidelines 2022 (No 1)

Notifiable instrument NI2022–602

made under the

Mental Health Act 2015, s 198A (Chief psychiatrist may make guidelines)

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1 Name of instrument

This instrument is the *Mental Health (Use of Restraint) Guidelines 2022 (No 1)**

2 Commencement

This instrument commences on the day after it is notified.

3 Direction

I make the attached Use of Restraint Guideline to set requirements for the use of restraint.

Dr Dinesh Arya
Chief Psychiatrist
22 November 2022

*Name amended under Legislation Act, s 60

ACT Government | ACT Health

CHIEF PSYCHIATRIST GUIDELINE

Use of restraint

PURPOSE	To ensure consistency and compliance in the appropriate and safe use of restraint.
COMPLIANCE STATEMENT	The legal basis for the use of restraint must be clear. The use of restraint must not severely, adversely affect a person in a manner and to a degree incompatible with the international human rights protection against torture and cruel, inhumane, and degrading treatment. In assessing whether the person has been so affected, regard must be had to their particular personality and 'vulnerability and their inability to complain coherently, or at all, about how they are being affected by any particular treatment'. (*Hurtado v. Switzerland [1994] - as cited in Mental Health Bill 2015 Explanatory Statement*) Use of restraint should be a last resort option to prevent serious and imminent harm to a person, another person or property. It must take account of the following: • Assessment and treatment, care or support that is recovery-orientated and provided in a way that is least restrictive. • A person should be subjected to restraint only if the treating clinicians are satisfied that it is the least restrictive treatment option to prevent the person from causing harm to themselves or someone else. • Restraint must be clinically indicated • Restraint must be applied using an approved method, by appropriately trained staff and with authority under the *Mental Health Act 2015.* • The person's clinical record must include documentation of the fact of restraint and the reasons for the restraint. • Review of the use of restraint undertaken must also be documented. • The Public Advocate must be informed in writing of the restraint and the nature and duration of the restraint. • A register of restraint must be maintained.

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	• A person should be advised of their rights of review.
SCOPE	This guideline applies to support, care and treatment provided in an approved mental health facility. Any breaches of this guideline must be reported to the Chief Psychiatrist. Health service providers must include reference to this guideline in their local policies and procedures related to the use of restraint. They must ensure that it is communicated to staff and that training is provided to make sure practices are consistent with this guideline. This guideline provides guidance to clinicians, and it is agreed that it should not limit police functions. Therefore, this guideline does not apply to Police exercising a function under the *Mental Health Act 2015*.
DEFINITIONS	**Chief Psychiatrist** is a psychiatrist and public servant appointed by the Minister for Mental Health. Functions of the Chief Psychiatrist include provision of treatment, care or support, rehabilitation and protection for persons who have a mental illness. **The Person in Charge** is a senior member of staff in charge of an approved mental health facility at any particular time. This is generally the Clinical Director, Assistant Director of Nursing (ADON), Clinical Nurse Consultant (CNC) or their delegate (after hours). **Restraint** is the interference with, or restriction of, a person's freedom of movement **(**whereas **Seclusion** is the involuntary confinement of a patient at any time of the day or night alone in a room or area from which free exit is prevented). Restraint can be: • **Physical restraint** is the application of bodily force to the person's body to restrict the person's movement. • **Mechanical restraint** is the application of devices (including belts, harnesses, manacles, sheets and straps) to a person's body to restrict their movement. Mechanical restraint can be used to prevent the person from harming themselves or endangering others, or to ensure that essential medical treatment can be provided. It does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's capacity to get off the furniture, except when the devices are only used to restrain a person's freedom of movement. The use of a medical or surgical appliance

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	for the proper treatment of physical disorder or injury is not considered mechanical restraint (National Qualityand Safety Health Care Standards, 2021).
ALERTS	Clinicians and staff who use restraint must be trained and approved through approved courses for de-escalation, aggression management and in the use of restraint.
DETAILED DESCRIPTION	**Reduction and elimination of restrictive practices** There is a commitment to reducing and where possible eliminating interventions that are considered restrictive. Use of these interventions (including the use of restraint) should be used as a last resort after a consideration of other less restrictive alternatives to prevent imminent harm to the person, others or to property. **Care must be trauma-informed** The experience of restraint can be traumatic, including for those who have a history of trauma. Care must always be trauma-informed. **Gender sensitivity** Restraint should be undertaken by people of the same gender as theperson, where possible. **Authorisation** The Chief Psychiatrist or delegate may authorise the restraint of a person if it is necessary and reasonable to prevent the person from causing harm to themselves or another person, or to ensure that the person remains in the approved mental health facility under the involuntary treatment order. **Application of restraint** Restraint must be least restrictive option available, involve the minimum number of people necessary, applied for the least duration possible and the least force required is used to ensure the safety of the person, staff and others. **Face down restraint** The face down position (also referred to as ‘prone restraint’) must be used as a last resort option. When face down restraint is used it should be for the minimum time period possible to administer medication or move the person to a safer place. **Review of restraint** Any person who is restrained must be examined by a doctor

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	following the restraint as soon as it is clinically safe. **Follow-up on termination of restraint** When the person is settled, the treating team should offer them the opportunity for debriefing and provide psychological support following restraint. This should include the person's understanding and experience of the incident; an explanation of the reason(s) restraint had to be used; whether the use of restraint was considered among other less restrictive alternatives; and other less restrictive interventions that may be helpful in the future. The person should be given a choice as to who they would like to discuss their experience with, wherever possible, and whether they would like to have a support person such as a guardian, patient advocate or carer present. **Clinical team debriefing** The clinical team involved in restraint must have debriefing to consider why the use of restraint was needed, a discussion of any other less restrictive alternatives that could have been used in the circumstances, the experience of staff involved, outcomes and any learnings. **Documentation** The following documentation must be completed in relation to above intervention: • The person's clinical record must include documentation of the fact of, and the reasons for the use of restraint and the nature and duration of the restraint used; • Whether a clinical debriefing in relation to the use of restraint took place; • The public advocate must be notified in writing. **Reduction and Elimination Plans** A person whose behaviour is repeatedly considered to be threatening to themselves or others and whose symptoms fail to respond to a full range of clinical interventions must be reviewed to explore other less restrictive strategies as an alternative to restraint.
IMPLEMENTATION	Services will disseminate this guideline to all staff. A service-specific policy or procedure may be developed consistent with this Chief Psychiatrist's guideline. A guideline comes into effect once notified on the ACT Legislation Register.

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RECORDS MANAGEMENT	All records are managed in accordance with the *Health Records (Privacy & Access)* Act 1997 (ACT), *Territory Records Act 2002* and ACT Health Directorate policy and procedures. All guidelines will be published on the Office of the Chief Psychiatrist | Health (act.gov.au) website. All guidelines are notifiable instrument and are available on the ACT Legislation Register at ACT Legislation Register.
RELATED LEGISLATION	*Mental Health Act 2015* *Mental Health (Secure Facilities) Act 2016* *Children and Young People Act 2008* *Human Rights Act 2004* *Legislation Act 2011* *Public Advocate Act 2005* *Work Health and Safety Act 2011* *Cares Recognition Act 2021*
SUPPORTING DOCUMENTS	*Australian Institute of Health and Welfare Data Dictionary 2015.* *National Quality and Safety Health Care Standards, 2021*

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