Mental Health Act 2016

Chief Psychiatrist Policy

Effective date: 5 March 2017
Review by: 5 March 2020
Supersedes: Nil

Mechanical Restraint

1. Purpose

This Policy outlines the relevant provisions of the *Mental Health Act 2016*, and the Chief Psychiatrist Policy, regarding the use of mechanical restraint on involuntary patients.

In line with national approaches, this Policy supports the reduction and elimination of mechanical restraint for patients. Mechanical restraint is to be used as a last resort to prevent imminent and serious risk of harm to patients and staff, where less restrictive interventions have been unsuccessful or are not feasible.

The following principles must be applied in the use of mechanical restraint:

- maintaining the safety, wellbeing and dignity of the patient is essential
- protecting the safety and wellbeing of staff is essential
- mechanical restraint should only be used for the minimum period of time necessary, and
- all staff actions should be justifiable and in proportion to the patient's behaviour and condition.

2. Scope

This Policy is mandatory for all authorised mental health services (AMHSs). An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act must comply with this Policy.

This Policy applies to the use of mechanical restraint in an AMHS. Separate provisions of the Act apply to the use of mechanical restraint to transport a person.

This Policy must be implemented in a way that is consistent with the Objects and Principles of the Act.

3. Authorising Legislation

Section 273 of the *Mental Health Act 2016*.

4. Background

The safeguards on the use of mechanical restraint of patients in an AMHS are outlined in Chapter 8, part 3 of the Act.

Mechanical restraint is the restraint of a person by the application of a device to the person's body, or a limb of the person to restrict the person's movement. Mechanical restraint does not include the appropriate use of a medical or surgical appliance in the treatment of physical illness or injury, or restraint that is authorised or permitted under another law.

The decision to use mechanical restraint is a last resort to prevent imminent and serious harm to the patient or another person, and only after less restrictive strategies have been trialled or appropriately considered and excluded. Mechanical restraint can only be used if there is no other reasonably practicable way to protect the patient or others from physical harm.

The use of mechanical restraint can cause significant and lasting distress and injury to both patients and staff. The potential harmful effects of mechanical restraint must be balanced against the risk of harm of the behaviour in question. Services must adopt evidence-based and best practice approaches to safely reduce and, where possible, eliminate the use of mechanical restraint.

Under the Act, mechanical restraint may only be applied to an involuntary patient in an AMHS who is subject to a treatment authority, forensic order or treatment support order, or a person absent without permission from another State who is detained in an AMHS.

Mechanical restraint:

- cannot be authorised under an advance health directive, or by an attorney or guardian
- can only be authorised by an authorised doctor
- can only be authorised for up to 3 hours, and
- may be applied for no more than 9 hours in a 24-hour period, but may be continued beyond this time if it is approved under a reduction and elimination plan.

An authorised doctor can only authorise mechanical restraint with the prior written approval of the Chief Psychiatrist (in urgent circumstances, verbal approval may be given by the Chief Psychiatrist, provided that this is confirmed by written approval as soon as practicable). An approval can only be for up to 7 days. The Chief Psychiatrist may also require that a reduction and elimination plan be prepared for the mechanical restraint to be used (see below).

The device to be used for mechanical restraint must be approved by the Chief Psychiatrist.

A patient must be continuously observed while a mechanical restraint is applied.

An authorised doctor must remove mechanical restraint if it is no longer necessary to protect the relevant patient or others from physical harm. The health practitioner in charge of the unit must also do this if the initial authorisation by the authorised doctor allows it. The Chief Psychiatrist may direct the removal of mechanical restraint.

5. Policy

When using mechanical restraint under the Act, staff must do all of the following

- use verbal strategies, de-escalation techniques and other evidence based strategies such as sensory modulation to help the patient safely gain control of their behaviour
- be appropriately trained to protect the welfare, dignity and safety of the patient (for staff using mechanical restraint under the Act, training must include de-escalation strategies, trauma-informed care, recovery-oriented practice, de-briefing strategies and the use of relevant mechanical restraint devices)
- as far as practicable in the circumstances, explain to the patient the reason for mechanical restraint, what will happen during the mechanical restraint (such as clinical observations, access to food and drink, access to the toilet), and the circumstances in which the restraint may be removed
- ensure that no more physical force is used to apply mechanical restraint than is necessary and reasonable in the circumstances
- ensure the patient is in a safe body position at all times; a prone (face down) position must not be used, airways must not be obstructed and there must not be prolonged compression of the chest or abdomen
- ensure the patient is in safe clothing and that personal items do not compromise the safety of the patient or staff; staff should also ensure the patient has access to physical aids they normally would use such as glasses, hearing aids or oxygen apparatus
- continuously observe the patient for indications of physical or mental distress; monitoring airways, breathing, circulation, skin integrity, body alignment and level of consciousness; for patients at additional risk, such as those who have been sedated, appropriate recording of oxygen saturation, pulse and blood pressure should be undertaken

- monitor patients where intramuscular or intravenous medication was administered within one hour prior to the use of mechanical restraint or during the mechanical restraint, and seek immediate medical treatment if there is a concern
- be aware that the use of CCTV is not sufficient as a way to continuously observe a patient being mechanically restrained
- use added caution with patients with an underlying medical or neurological condition, patients who are intoxicated or have acute behavioural disturbance or 'excited delirium'.[1]
- be aware of heightened vulnerability to significant psychological trauma from restraint, especially for minors, patients with a history of trauma, abuse or detention, and patients of Aboriginal and Torres Strait Islander backgrounds
- conduct a review with all staff involved in the mechanical restraint as soon as practicable after the event to evaluate the triggers which resulted in the need to mechanical restrain the patient and the methods used to respond to the event
- consider debriefing staff following the mechanical restraint event in accordance with local policy and procedures
- conduct a debriefing with the patient involved in the mechanical restraint (with the patient's consent), and with other patients involved in any event that led to the mechanical restraint, as soon as clinically appropriate after the event (include support persons such as a family member or peer worker where possible and appropriate), and,
- complete all required reports and documentation.

These requirements are in addition to those outlined in section 251(b) of the Act, namely that the patient must be provided with:

- sufficient bedding and clothing
- sufficient food and drink, and
- access to toilet facilities.

Mechanical restraint must not be used:

- as a substitute for other less restrictive interventions
- as a form of discipline or punishment
- as a substitute for adequate staffing levels
- as a substitute for staff training in crisis prevention and intervention to manage aggressive, harmful behaviours, or
- when seclusion is being used simultaneously.

Each authorisation of mechanical restraint by an authorised doctor requires a separate medical review of the patient and written authorisation, even when authorisation immediately follows a previous authorisation.

A medical review must occur at the end of each mechanical restraint event.

5.1. Reduction and Elimination Plans

A reduction and elimination plan outlines measures to be taken to reduce and eliminate the use of mechanical restraint on a patient and to reduce the potential for trauma and harm. The plan reinforces efforts to proactively reduce the use of mechanical restraint on a patient by ensuring clinical leadership, monitoring, accountability and a focus on safe, less restrictive alternatives to mechanical restraint.

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[1] 'Excited delirium' is a term used to describe an extreme form of behavioural disturbance characterised by severe agitation, aggression, paranoia, unusual strength and numbness to pain. Patients exhibit delirium and extreme hyperthermia. Excited delirium can result in sudden death.

It is recommended practice that a reduction and elimination plan to be in place in all instances where a patient is mechanically restrained. A single reduction and elimination plan may apply to both mechanical restraint and seclusion. However, seclusion and mechanical restraint must not be used simultaneously.

The Chief Psychiatrist may require a reduction and elimination plan for a patient under section 248 of the Act.

The Plan must include the following details:

- the name and date of birth of the patient
- the name of the AMHS
- any previous use of mechanical restraint on the patient
- any strategies previously used to reduce the use of mechanical restraint of the patient and the effectiveness of the strategies
- a description of the behaviour that has led to the proposed mechanical restraint
- a description of significant risks to the patient or others
- the reasons that the authorised doctor believes there is no other reasonably practicable way to protect the patient or others from physical harm
- the proposed frequency and duration of the mechanical restraint, and
- the strategies proposed to reduce and eliminate the use of mechanical restraint.

5.2. Recording

The application to use mechanical restraint under section 247(2) of the Act, the authorisation under section 250(2) of the Act and the actual times and duration of each mechanical restraint event by AMHS staff must be recorded on CIMHA.

The following information must also be recorded in the patient's clinical record, wherever possible, on CIMHA:

- the reasons for the mechanical restraint, including the events that led to the mechanical restraint
- why there was no other reasonably practicable way to protect the patient or others from physical harm, including any strategies used to prevent the need for mechanical restraint
- clinically relevant details regarding the patient's physical and mental health status at the time of the mechanical restraint, including signs of alcohol or drug intoxication or withdrawal
- the patient's behaviour during the mechanical restraint
- whether physical restraint or seclusion directly preceded a mechanical restraint event
- medications administered up to one hour prior, during and immediately after the mechanical restraint (medication name, dosage, frequency and route of administration)
- any adverse events relating to the mechanical restraint
- the results of all clinical reviews of the patient required by this Policy, including the examinations that took place during and immediately after the mechanical restraint, and
- post-event debriefing of the patient, staff and any other relevant persons.

5.3. Notifications

The Chief Psychiatrist must be notified immediately where mechanical restraint results in, or is associated with:

- the death of a patient during or within 24 hours following mechanical restraint of the patient, or
- significant harm to a patient or other person during mechanical restraint or within 24 hours following mechanical restraint of the patient.

Community visitors under the *Public Guardian Act 2014* may request information about the use of mechanical restraint on minors in an AMHS. AMHS staff must provide information as recorded under section 5.2 of this Policy when requested by a community visitor (whether or not it is during or connected with a visit).

5.4. Monitoring and Reporting

Monitoring the use of mechanical restraint, the types of events that result in the use of mechanical restraint, effective management strategies and any adverse events is a necessary part of reducing and eliminating mechanical restraint.

Data will be publically reported in the Chief Psychiatrist Annual Report in accordance with national standards.

6. Supporting Documents

- Nil

Issued under section 273 of the Mental Health Act 2016

Assoc. Prof John Allan
Chief Psychiatrist, Queensland Health
5 March 2017