

Chemical Restraint



Chief Civil Psychiatrist Clinical Guideline 10

Provisions to Which the Guideline Relates

Mental Health Act 2013 – sections 3, 6, 15, 57, 58 and Schedule 1 (extracted at Appendix 1).

Preamble

Chemical restraint is a very restrictive intervention, the application of which may cause distress for patients, support persons and staff members. For this reason chemical restraint may only lawfully be applied when absolutely necessary, and when less restrictive interventions have been tried without success, or have been considered but excluded as inappropriate or unsuitable in the circumstances.

Purpose

This Clinical Guideline is intended to provide practical assistance to controlling authorities, medical practitioners, nurses and other staff members of approved hospitals and approved assessment centres in the exercise of responsibilities relating to the chemical restraint of involuntary patients under the *Mental Health Act 2013*, and related matters.

The Guideline is designed to ensure that chemical restraint is used minimally, and that when it is used it is used appropriately, safely and in a way that respects the dignity and rights of patients.

Failure by an individual to have regard to this Guideline is not an offence but may, particularly if the failure leads to unfavourable patient outcomes that might otherwise have been avoided or if there is a history of such disregard, constitute proper grounds for instituting professional or, as the case may be, occupational disciplinary action against that individual.

Guideline

I, Professor Kenneth Clifford Kirkby, being and as the Chief Forensic Psychiatrist, pursuant to sections 151 and 153 of the *Mental Health Act 2013* and section 22 of the *Acts Interpretation Act 1931* hereby:

1. Revoke all previous directions (clinical guideline) issued under section 152 of the *Mental Health Act 2013* with respect to the exercise of responsibilities in relation to authorising chemical restraint with effect from 11.59 pm on 30 June 2017; and

2. Issue the following direction (clinical guideline) to controlling authorities (and delegates) and authorised persons exercising responsibilities in relation to authorising chemical restraint under the *Mental Health Act 2013*, and related matters, with effect from 12.00 am on 1 July 2017.

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What is chemical restraint?

Chemical restraint is not a form of treatment. Rather, it is medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition.

Some medications that are used to reduce symptoms of physical conditions or medically identified major mental illnesses have side effects. This may include sedating the person to whom they are given.

The appropriate use of medications which have such side effects to reduce or manage symptoms of diagnosed anxiety, depression or psychosis is not chemical restraint.

Similarly, the prescription of medications to control the disordered behaviour of a person with an underlying medical condition such as a delirium or dementia is not chemical restraint.

Rather, chemical restraint occurs when medication is intentionally given to exert control over a patient's movements or behaviour.

Chemical restraint may involve the administration of higher than usual doses of a person's regular medication; or the administration of psychotropic medication (alone or in combination, whether given orally or by intramuscular or intravenous routes) to a person who does not have a diagnosed mental illness.

Whether or not the giving of medication constitutes chemical restraint will effectively depend on why the medical practitioner in question is giving the particular patient the medication that is being given, at the relevant time. Clinical factors which may be taken into account in determining this include:

- The nature of the patient's condition and whether the medication is being given to address symptoms of the patient's condition, or for another reason. Whether or not the patient has been diagnosed with a mental illness and the nature of medication that would usually be given to address symptoms of the illness that has been diagnosed, may be of relevance, and
- Whether the medication is given as the last step in a series of escalating interventions which have been tried without success or with limited success.

Does This Include Treatment of Acute Agitation Syndromes?

Chemical restraint is defined in section 3(1) of the *Mental Health Act 2013* to mean:

"medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition".

Note should be made of the use of the word "primarily" which may lead to a consideration of the intent of prescribing the medication and also to confusion and ambiguity if the medication has the effect of both controlling behaviour and treating the underlying condition.

The general intent and objectives of the *Mental Health Act* are clear – the provision of treatment in the least restrictive setting in a manner consistent with the clinical needs of the patient and the safety and welfare of all persons involved with the patient.

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All clinicians will recognise that acute agitation is a common psychiatric emergency, manifesting in at least 10-25% of emergency psychiatric presentations and is frequently seen in all acute mental health settings. These presentations are associated with a high risk of harm to the patient and to others. Non-pharmacological interventions may not be successful or effective in a safe timeframe. Pharmacological agents, particularly Benzodiazepines and anti-psychotic agents, either alone or in combination are frequently used to treat acute agitation syndromes to minimise the risk of injury and to stabilise the clinical course.

In Tasmania, to follow the spirit of the Act and to minimise ambiguity, treatment of acute agitation syndromes should be administered according to the same standing orders and guidelines as are applicable for chemical restraint.

Reducing the Use of Chemical Restraint

While chemical restraint can provide safety and containment at a time when this is needed to protect involuntary patients, staff and others, it can also be a source of distress not only for the patient but also for support persons, representatives, other patients, staff and visitors.

Wherever possible, alternative, less restrictive ways of managing a patient's behaviour should be used, and the use of chemical restraint minimised. This can be achieved through the adoption of a prevention and early intervention framework.

Prevention and early intervention practices rely on reducing the risk factors for aggression or violence as well as enhancing the protective factors that promote a safe, secure, understanding and accepting environment.

Mental health care and the environment in which it is delivered are intended to optimise the safety and wellbeing of patients. Prevention and early intervention activities are aimed at improving the overall experience of patients and include, for example, strategies aimed at building connectedness, inclusion and a sense of acceptance.

Appropriate prevention and early intervention strategies can assist to reduce the circumstances in which the need to chemically restrain a patient arise. A range of these strategies are included in this section of the Guideline.

Inclusion of Patients and Support Persons

There is a greater chance of avoiding the need to use restrictive interventions when inpatient care involves patients, their representatives and support persons.

It should not be assumed that patients, or their representatives or support persons will be aware that the person may be chemically restrained while an involuntary inpatient in an approved hospital or approved assessment centre.

On admission of a person to an approved hospital or approved assessment centre, every effort should be made to provide information about restraint practices, particularly where the person has a history of, or potential for, aggression, or where there are concerns related to the safety of others. In practice

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this may be achieved through providing patients with access to this document and to Chief Civil Psychiatrist Standing Order 10: Chemical Restraint.

Staff should listen to concerns expressed by patients, and by their representatives and support persons about the use of chemical restraint and should provide information which may address concerns, and answers to any questions asked, whenever needed.

While it is appropriate to provide information to representatives and support persons in this way care should be taken to ensure that information which is specific to the patient and their restraint is provided to others only when the patient consents.

Restraint Care Planning to Minimise the Risk of Restraint or Repeat Restraint

Care planning that takes into consideration individual patient needs, preferences and experiences of which interventions are most effective should occur in relation to restraint for all patients.

Restraint care planning should consider the patient's primary diagnosis and involve an assessment of the patient's clinical needs, treatment objectives and outcomes, management of any underlying conditions, appropriate communication with the patient about what behaviours are unacceptable, and incorporate the development of a written restraint management or safety plan for the issues identified. The plan should in particular address individual patient, staff and environmental triggers.

In circumstances where chemical restraint is likely to be necessary, planning should also consider the individual's safety and care needs while being restrained, particularly for patients who are assessed as likely to present with acutely disturbed or aggressive behaviours, for those who require repeated episodes of restraint or where there is considered to be a need to restrain a patient who is extremely disturbed immediately after the patient's arrival at an approved assessment centre or approved hospital.

Care planning should also involve:

- Identifying mental and physical health problems and risks, and how they are to be managed
- Determining the frequency and nature of clinical observations required to be performed. This may include physical (respiration, pallor or cyanosis, posture, level of consciousness, motor activity, blood pressure and pulse) and mental state (pattern and content of speech, thought content, mood, affect, concentration, attention and level of motor activity) observations
- Identifying the time and frequency of medical examinations required to be performed
- Identifying the patient's bedding and clothing needs and how these are to be met
- Identifying the patient's need to have access to communication or physical aids while being restrained and an indication of how these needs are to be managed
- Identifying the patient's hygiene and toileting needs and making arrangements for these to be met
- Identifying the patient's dietary needs and arranging for these to be met. At a minimum this should involve fluid being offered to the patient at least every two hours and food being offered at least every four hours, except overnight when this may not be desirable. It may be

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appropriate for the patient to be supplied with a plastic cup and container of water. A fluid balance chart should be commenced for a patient who is likely to experience the effects of chemical restraint for more than four hours

- Establishing when the care plan itself should be reviewed.

Where chemical restraint involves medication being given in large doses or the giving of medication which is likely to be in effect some hours later, it is good clinical practice to obtain a second opinion or hold a case conference to review the patient's management as soon as practicable.

Diagnosis and Management of Underlying Conditions

Patients who repeatedly behave in a manner that threatens themselves or others and whose symptoms fail to respond to a full range of clinical interventions pose particular clinical challenges. Careful consideration and management may be required.

A thorough review of the patient's history, treatments attempted and their duration, and doses of medication administered and the patient's responses to these should be undertaken by the treating team, and may be the subject of a case conference. A second opinion external to the treating team may also be sought.

A restraint management or safety plan that is developed for the patient should describe the behaviour in question; should identify, wherever possible, the precipitating and exacerbating factors; and should suggest a graded series of responses. The plan should include strategies aimed at reducing the behaviour and the need for such restrictive interventions.

Advance Safety Plans for Chemical Restraint

For those who are at high risk of chemical restraint or who have been chemically restrained in the past, a collaborative advance safety plan for chemical restraint may be useful.

This should address patient concerns and vulnerabilities. For example, a patient with a history of a specific form of assault may become agitated where physical restraint that reminds them of this assault, is used. In other instances a patient may prefer oral rather than intramuscular medication when severely distressed.

Authorising Chemical Restraint

The decision to seek authorisation to give a patient chemical restraint should only be taken after less restrictive and/or more appropriate options for managing the patient's behaviour have been seriously considered and either tried without success or excluded as appropriate or suitable responses in the circumstances.

Matters to be taken into account when deciding whether or not to seek authorisation to give chemical restraint include the consequence of not using chemical restraint, for example the prolonged use of mechanical or physical restraint. The patient's preferences around the use of chemical restraint in favour of prolonged use of physical or mechanical restraint may be a factor.

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The need to give chemical restraint so that a patient can be properly assessed with respect to a mental illness and/or so that a patient can be given treatment to address symptoms of a diagnosed mental illness or general condition may also be a factor.

Managing Chemical Restraint

Communication Considerations

A patient for whom chemical restraint is authorised should be told that he or she is being chemically restrained, and should be informed of the period for which the chemical restraint is expected to have a sedating effect. Any extension of the period for which chemical restraint may be given and/or any repeat authorisation of chemical restraint should be similarly communicated.

Attempts should be made to inform a patient's representatives and/or support persons that the patient has been chemically restrained as soon as practicable after the chemical restraint has been administered, and of the period for which the chemical restraint is expected to have a sedating effect, to the extent that this is consistent with the patient's wishes. Information and support should be offered to representatives and/or support persons as and when needed.

The Act requires a patient who has been chemically restrained to be given a statement of rights as soon as practicable after the decision is made to give the chemical restraint. This requirement may be discharged while the patient is subject to the chemical restraint which has been authorised, or at a later point. Consideration should be given to having a member of nursing staff read the statement to a patient who is significantly unwell and/or considered otherwise unlikely to fully understand the content of any written statement that is provided, pending the provision of a written statement to the patient once this is considered to be clinically appropriate.

Clinical Considerations

A patient for whom chemical restraint is considered to be necessary should be thoroughly medically assessed. This should occur either prior to, or as soon as possible after, a patient is chemically restrained.

Particular emphasis should be placed on seeking a history of the presentation from the patient and their support persons, as well as other relevant/significant people. This should include information about the possible ingestion of alcohol, illicit drugs, over-the-counter medication and prescription medication that may have been ingested as overdose, deliberate or accidental. Information on medication prescribed should also be obtained.

The assessment should be as thorough as the circumstances allow and should include an assessment of the risk to the patient from deliberate or accidental self-harm.

Medication Considerations

The Act requires the administration of any prescribed medication to a patient who is chemically restrained, not to be unreasonably denied or delayed.

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In circumstances where it is difficult to thoroughly medically assess the patient, the risk of adverse effects from medication is greatly increased. Factors to be taken into account in deciding whether or not prescribed medication should be given include the safety and wellbeing of the patient, any medication already prescribed and administered and the likely interaction of these with the prescribed medication proposed to be given, the nature of the medication given to chemically restrain the patient and the likely interaction of this with the prescribed medication proposed to be given, the patient's ongoing management needs, whether giving the medication is consistent with achieving the best treatment outcomes in the shortest possible time, and the safety of other patients and staff if the medication is given or is not given.

Medical staff prescribing for people who are or may be chemically restrained must be familiar with the possible adverse effects of any medication prescribed and the cumulative effects of the medication from repeated administration. Prescribing psychotropic medication should be in accordance with accepted guidelines.

Staff should in particular be aware that the use or withdrawal from benzodiazepines, tobacco or other drugs may heighten anxiety and aggression in some people.

Use of Security Personnel

Security staff involved in restraint procedures should be under the direct authority and supervision of the senior registered nurse on duty or medical practitioner present, at all stages of a patient's restraint.

Any concerns about the individual practices of staff involved in these procedures should be escalated to a senior manager.

Special Considerations

Patients with a History of Trauma

Restraint of any type can trigger extreme responses from some individuals, including those who have a history of trauma. Responses may include flashbacks, hallucinations, dissociation, aggression, self-injury and depression.

Patients with a history of trauma who are restrained may feel they are being punished. They may be confused by the use of force by staff and may feel unsafe and unprotected from harm. They may also feel bitter and angry.

Research suggests a very high prevalence of traumatic experiences in persons who receive mental health services. A majority of adults and children in inpatient psychiatric treatment settings present with trauma histories and there are certainly others whose trauma histories haven't become known yet.

For this reason, as a universal precaution, it should be presumed that every person in a treatment setting has been exposed to trauma.

Advance safety plans may also be particularly useful for patients with an identified history of trauma.

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Gender Safety and Sensitivity

Given the high incidence of previous experiences of trauma among involuntary patients and given that restrictive practices including chemical restraint may potentially retrigger previous experiences of trauma in some people, services should ensure that staff demonstrate sensitivity to individual patient's needs and wellbeing in carrying out such interventions, particularly with regard to gender.

For example, restraint may be experienced by the patient as particularly traumatic or humiliating where nursing and security staff are predominantly male or female. As such, different patients may have different preferences about the gender of staff involved in the intervention. Where possible, the patient's preferences should be sought and responded to.

Arrangements for clothing, toileting and observation and examination requirements should also be undertaken in regard to their gender sensitivity.

Consideration should also be given to the possibility of pregnancy in female patients and the implications of this, especially for the use of medications.

Patients with Intellectual Disability or Acquired Brain Injury

A person with an intellectual disability or acquired brain injury may communicate primarily through their behaviour. This may particularly be the case where other means of communication are impaired by mental illness.

Problematic behaviour from patients with intellectual disability or acquired brain injury should be assessed, wherever possible, for meaning before the decision is taken to use chemical restraint.

Staff should always assess the patient's mental state and consider that the patient may be experiencing hallucinations or mood disturbance. It is also important to consider mental state abnormalities resulting from an underlying illness that may be exacerbating a patient's behaviour; and a patient for whom agitated or violent behaviour is a new phenomenon should be carefully assessed for an underlying medical condition.

It is important, wherever possible, for the nature of the intervention and the reasons for it to be explained at a level the patient is able to comprehend, preferably before the patient is restrained.

It is also important to consider the existence and involvement of the patient's representatives, including guardians.

Children and Adolescents

Special consideration should be given to the risks of using neuroleptic medication to sedate a child or adolescent who has a developing central nervous system, especially when such medication is given to children and adolescents who are not psychotic.

While the parent or guardian of a young person should be informed of an episode of chemical or other restraint as soon as practicable and involved in the debriefing process wherever possible, a decision to involve a parent or guardian must take into account the child's capacity to consent to their

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involvement, and the child's views about this. This may involve considering whether or not the child is capable of fully understanding the nature and consequences of the decision to involve the parent and the child's ability to communicate his or her decision.

Careful assessment by a trained child and adolescent clinician is required (especially for those children and adolescents with histories of trauma and abuse) where other strategies to de-escalate behaviours are more appropriate than the use of chemical restraint.

Older Persons

Disturbed behaviour in older people – particularly those with dementia – may be a result of medical illness, physical discomfort, sensory impairment or the presence of unmet needs which cannot easily be communicated to staff.

Particular care should be given to supporting older patients to communicate through use of short, clear sentences in a lower tone of voice, employing active listening skills to hear what the patient may be trying to communicate.

The possibility of delirium must be considered in the assessment of any older patient who is becoming agitated, distressed or confused or for whom chemical restraint is being considered. Matters which may be associated with delirium such as hypoxia, hypertension, hypoglycaemia, major electrolyte disturbance, infection, urinary retention, constipation and faecal impaction along with pain, thirst, hunger and alcohol withdrawal syndrome should be considered along with any other clinical factors that may require management including depression or anxiety and any new neurological deficits.

At times a patient's distress may be reduced through the application of comfort factors including positioning, immobility, provision of communication aids including hearing aids or glasses, activity to alleviate boredom, toileting needs, thirst, loneliness or lack of activity, or modification of environmental factors such as noise, temperature or lighting.

The vulnerability of older patients – particularly the increased risk of falls - should be a consideration in any decision to apply restraint and should be taken into account in the restraint process.

Communication with Patients from Culturally and Linguistically Diverse Backgrounds

Any form of restraint including chemical restraint may be more traumatic and potentially more dangerous for those who are unable to understand what is happening or unable to communicate their questions or concerns. The use of professional interpreters must be considered in these situations.

Patients may perceive or interpret the use of force differently depending on their cultural backgrounds and personal experiences as a refugee or a survivor of abuse or torture.

It is important to be aware that communication problems in themselves may lead to unnecessary interventions. Special care should be taken to achieve effective communication, first to avert the use of chemical restraint, if possible, and second, to minimise the trauma of the intervention to the patient both during and after the intervention. The use of interpreters and availability of communication aids whilst the patient is subject to the effects of chemical restraint should be considered in these situations.

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Every effort should be made to understand and respond to cultural sensitivities by, for example, providing language services and by taking into account the gender of direct care staff.

Communication with Patients with Sensory Impairment

Chemical or other forms of restraint may also be more traumatic and potentially more dangerous for patients who may be unable to understand what is happening or unable to communicate their questions or concerns due to sensory impairment. Specific interventions, such as the restraint of a deaf person's hands, may also prevent effective communication.

Special care should be taken in these situations to achieve effective communication, first to avert the use of chemical restraint, if possible, and second, to minimise the trauma of the intervention to the patient both during and after the intervention. The use of carers who are familiar with the communication needs of the patient and the availability of communication aids required by the patient to communicate on a daily basis should be considered in these situations.

Consent to Acute Sedation

A voluntary patient cannot lawfully be chemically restrained under the *Mental Health Act 2013*.

However, a voluntary patient who is legally capable of consenting may consent to being given sedative medication.

The patient's written consent to the medication proposed to be given should be obtained, prior to it being administered. This should be accompanied by a written statement from the patient's treating medical practitioner or a senior nurse on duty confirming the patient's capacity to provide consent to the medication.

The principles outlined in this Guideline should be applied to the extent that they are relevant, to the giving of acute sedation to a patient with consent.

Should the behaviour of a voluntary patient meet the criteria for being chemically restrained, consideration should be given to whether the patient meets the assessment or treatment criteria with steps taken to obtaining an Assessment Order or Treatment Order if this is the case.

Observation and Examination Requirements

Once the decision has been made to use chemical restraint, careful assessment of the patient's safety needs is essential, together with clinical monitoring, support and review.

Clinical Observation Requirements

Given the need for continuous monitoring of a patient who has been chemically restrained, a monitoring nurse must be stationed to sit with and clinically observe the patient who has been chemically restrained. This should involve:

- Monitoring the patient's vital signs including details of the patient's pulse, respiration, blood pressure, posture, muscle tone, level of consciousness and comfort level, and

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- Mental status observation including the patient's pattern and content of speech, attention, level of motor activity and orientation.

Particular emphasis should be placed on seeking the patient's history at the first examination. This should include information about the possible ingestion of alcohol or illicit drugs, and of deliberate or accidental overdose of prescribed medications, and any history of suicide attempts by the patient, and involve:

- A review of the patient's physical and mental health status, and
- An assessment of the adverse effects of medication, and
- A reassessment of the medication prescribed, and
- An assessment of the risk to the patient from deliberate or accidental self-harm, and
- An assessment of the potential or likely need for repeat application of chemical restraint.

Occasionally a patient whose mental state and reasoning is profoundly impaired by their illness is admitted to an inpatient unit. Patients in this state may be unable or unwilling to give coherent responses to questions and/or are aggressively opposed to being physically examined. While this makes adequate assessment difficult, as thorough an assessment of the patient as is possible should take place before any medication is administered.

Staff must be alert to the possibility that the patient who appears to be asleep may actually be unconscious. Where a patient appears to be asleep while under the effects of chemical restraint, clinical staff should be alert to and assess the level of consciousness and respirations of the patient to exclude the possibility of an altered level of consciousness or respiratory distress.

Communication with the Treating Team

A senior member of the treating team should be informed of a patient's chemical restraint as soon as is reasonably practicable in order to inform ongoing management decisions associated with the patient.

Clear systems and processes should be in place to communicate to relevant clinical staff across successive shifts. In particular, details regarding the reasons for the use of chemical restraint, the current plan and previous treatments provided should be clearly communicated at handover points and be available in the clinical record. The clinical record should contain up-to-date documentation such as risk assessments, restraint management or safety plans, observation charts, medical reviews and communication with other parties - for example, support persons.

Once Chemical Restraint Has Ended

Post-Restraint Patient Support

Although chemical restraint may be used for sound clinical reasons, it is a potentially traumatic intervention that requires sensitivity and skill in its management.

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Once the patient is settled and willing to discuss the incident leading to chemical restraint, the patient's understanding and experience of the incident should be explored and the reasons restraint was used and other interventions deemed ineffective or inappropriate explained to the patient.

The patient should be allowed to discuss their experience of being chemically restrained and of any restraint reviews conducted.

Staff must be aware that the purpose of a post-restraint discussion with the patient is to provide an opportunity for the individual's experience of the episode to be discussed. Attempts by staff to justify the decision to restrain may be counterproductive.

The patient should be given a choice as to who they would like to discuss their experience with, wherever possible.

Consideration should be given to the sensitive reintegration of the patient into the general inpatient population because patients might consider chemical restraint as embarrassing or humiliating.

Clinical staff members also need to be aware of how the patient and others in the inpatient unit are affected by the use of chemical restraint. Staff should offer information on chemical restraint to visitors and to other people (including other patients) who have witnessed the application of chemical restraint.

Documentation and Review

Following the cessation of a chemical restraint episode, a formal chemical restraint review meeting should occur as soon as possible. This should involve at least the unit manager, senior registered nurses and consultant psychiatrist.

Wherever possible, the patient and his or her carers and family members should be encouraged to participate in the relevant parts of the review process.

The aim of the review meeting is to:

- Review the chemical restraint episode including the lead up to the application of chemical restraint
- Identify preventative strategies trialled and the reasons for failure
- Review compliance with the Act
- Review system-wide management issues that may need addressing to prevent further chemical restraint episodes
- Consider what else might have been done to prevent or minimise the disturbed behaviour
- Update clinical risk assessments relating to the patient and the patient's care plan.

Any systemic issues identified in the formal review are to be forwarded to the relevant safety and quality improvement committee for attention.

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Guidance for Controlling Authorities

Controlling authorities of approved assessment centres and approved hospitals should consider the requirements of the *Mental Health Act 2013* when designing or designating rooms or areas in which patients may be chemically restrained. In particular controlling authorities should consider matters such as ventilation and light, and the ability for patients who are chemically restrained within such rooms or spaces to seek help from nursing or medical staff members.

Controlling authorities should also consider putting in place processes to ensure that patients who are chemically restrained are able to keep track of time.

Controlling authorities should also ensure that staff members who are required, or potentially required, to exercise functions and powers relating to chemical restraint are educated and trained on the safe use of chemical restraint and on the requirements of the *Mental Health Act 2013* as it relates to chemical restraint, and other forms of restraint. This includes contracted security personnel.

Controlling authorities should consider including the following matters within the scope of quality assurance and review activities:

- The extent to which staff know how to apply the framework established by the Act and are aware of this Guideline, relevant Chief Civil Psychiatrist Standing Orders and any local policies and procedures associated with chemical restraint and acute sedation
- The reasons underpinning the application of chemical restraint
- The prolonged or repeated use of chemical restraint
- The use of chemical restraint overnight
- Risk assessments conducted prior to and during chemical restraint
- Injuries or other incidents occurring in the lead up to the application of chemical restraint, or while the patient is under the effects of chemical restraint
- Restraint care planning and advance safety planning
- The use and effectiveness of strategies to reduce the use of chemical restraint
- The use of medication in respect of patients who are chemically restrained
- Patient and support person perceptions of chemical restraint.

Findings from activities conducted should be used to inform the development of training programs for staff.

Guidance for Clinical Staff

Staff members working within approved assessment centres and approved hospitals should ensure that they have a sound knowledge of the *Mental Health Act 2013*, this Guideline, relevant Chief Civil Psychiatrist Standing Orders and of any local policies and procedures relating to the use of chemical restraint and acute sedation which may be in place from time to time.

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Staff members who are directly involved in the provision of patient care should ensure that they receive specific training in how to ensure that chemical restraint is used minimally and safely, and in de-escalation techniques.

Staff likely to be involved in the application of chemical restraint should also ensure that they receive training in observation and monitoring of patients who are chemically restrained and recognising signs of mental and physical distress in a patient who is chemically restrained.

At the completion of training staff should be able to demonstrate an understanding of:

- Legislation governing the use of chemical restraint in Tasmania
- How patients experience chemical restraint
- Underlying causes of aggressive or threatening behaviours
- Aggressive behaviours that may be related to a medical condition
- The impact of their own behaviours and attitudes on patients
- Use of de-escalation techniques

A handwritten signature in black ink, appearing to read 'Ken Kirkby'.

Professor Kenneth Clifford Kirkby

Chief Civil Psychiatrist

Date: 1 July 2017

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Appendix I: Relevant Legislative Provisions

3. Interpretation

adult means a person who has attained the age of 18 years

approved assessment centre means an assessment centre that is approved under section 140 of the Act.

assessment order means an assessment order made under Division 1 of Part 3 of Chapter 2 of the Act.

approved facility means an approved hospital, an approved assessment centre or a secure mental health unit.

approved hospital means a hospital that is approved under section 140 of the Act.

approved medical practitioner means a person who has been approved by a Chief Psychiatrist under section 138 of the Act.

approved nurse means a person who has been approved by a Chief Psychiatrist under section 138 of the Act.

chemical restraint means medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition

Chief Civil Psychiatrist means the person for the time being holding or acting in the office referred to in section 143 of the Act. The Chief Civil Psychiatrist has responsibility for ensuring that the objects of the Act are met in respect of patients other than forensic patients or persons who are subject to supervision orders, and for the running of approved facilities other than secure mental health units.

child means a person who has not attained the age of 18 years

communication aid means any electronic or other device used to assist a person to communicate

controlling authority means –

(a) for an approved facility run by or on behalf of the State, the Secretary, Department of Health and Human Services; and

(b) for any other approved facility, the person for the time being in overall charge of the day-to-day clinical management of that facility

involuntary patient means a person who is subject to an assessment order or treatment order

mechanical restraint means a device that controls a person's freedom of movement

parent, of a child, means a person having, for the child, all of the responsibilities which, by law, a parent has in relation to his or her children

physical aids includes –

(a) spectacles and hearing aids; and

(b) prostheses; and

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(c) inhalers, ventilators and oxygen apparatuses; and

(d) crutches, wheelchairs and walking frames

physical restraint means bodily force that controls a person's freedom of movement

representative, of a patient or prospective patient, means –

(a) the patient's guardian; or

(b) the patient's Australian lawyer; or

(c) if the patient is a child and raises no objection, a parent of the patient; or

(d) any other person nominated by the patient to represent his or her interests

statement of rights means a written statement that sets out and succinctly explains, in plain language, what rights a patient or prospective patient has in the particular circumstances under this Act in which he or she is required to be given such a statement

support person, of a patient or prospective patient, means a person who provides the patient with ongoing care or support

treating medical practitioner means the medical practitioner who is responsible for a patient's treatment or proposed treatment

treatment means the professional intervention necessary to prevent or remedy mental illness; manage and alleviate, where possible, the ill effects of mental illness; or reduce the risks that persons with mental illness may, on that account, pose to themselves or others; or to monitor or evaluate a person's mental state.

treatment order means a treatment order made under Division 2 of Part 3 of Chapter 2 of the Act, and includes an interim treatment order made under section 38 of the Act.

6. Meaning of treatment

(1) For the purposes of this Act, treatment is the professional intervention necessary to –

(a) prevent or remedy mental illness; or

(b) manage and alleviate, where possible, the ill effects of mental illness; or

(c) reduce the risks that persons with mental illness may, on that account, pose to themselves or others; or

(d) monitor or evaluate a person's mental state.

(2) However, this professional intervention does not extend to –

(a) special psychiatric treatment; or

(b) a termination of pregnancy; or

(c) a procedure that could render a person permanently infertile; or

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(d) the removal, for transplantation, of human tissue that cannot thereafter be replaced by natural processes of growth or repair; or

(e) general health care.

(3) For the purposes of this Act, "treatment" does not include seclusion, chemical restraint, mechanical restraint or physical restraint.

15. Mental health service delivery principles

All persons exercising responsibilities under this Act are to have regard to the mental health service delivery principles set out in Schedule 1.

57. Restraint

(1) Except if authorised under any other law, an involuntary patient who is not a forensic patient may be placed under restraint if, and only if –

(a) the patient is in an approved assessment centre or approved hospital; and

(b) the restraint is authorised as being necessary for a prescribed reason by –

(i) in the case of chemical or mechanical restraint, the CCP; or

(ii) in the case of physical restraint where the patient is a child, the CCP; or

(iii) in the case of physical restraint where the patient is not a child, the CCP, a medical practitioner or an approved nurse; and

(c) the person authorising the restraint is satisfied that it is a reasonable intervention in the circumstances; and

(d) the restraint lasts for no longer than authorised under this section; and

(e) the means of restraint employed in the specific case is, in the case of a mechanical restraint, approved in advance by the CCP; and

(f) the restraint is managed in accordance with any relevant CCP standing orders or clinical guidelines.

(2) If an involuntary patient who is not a forensic patient is placed under restraint under this section –

(a) the patient must be clinically observed by a member of the approved hospital's nursing staff at intervals not exceeding 15 minutes or at such different intervals as CCP standing orders may mandate; and

(b) the patient must be examined by a medical practitioner or approved nurse at intervals not exceeding 4 hours to see if the restraint should continue or be terminated; and

(c) the patient must also be examined by an approved medical practitioner at intervals, each of not more than 12 hours; and

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- (d) *the restraint must not be applied beyond 7 hours unless –*
 - (i) *the patient has been examined by a medical practitioner within those 7 hours; and*
 - (ii) *the extension is authorised by the CCP within those 7 hours; and*
 - (iii) *if applicable, each subsequent extension (regardless of duration) is also authorised in advance by the CCP; and*
 - (e) *the CCP may impose conditions on any extension authorised under paragraph (d); and*
 - (f) *the CCP, on authorising an initial extension of the restraint, must stipulate the maximum timeframe for its continuance; and*
 - (g) *the patient must be provided with –*
 - (i) *suitable clean clothing and bedding; and*
 - (ii) *adequate sustenance; and*
 - (iii) *adequate toilet and sanitary arrangements; and*
 - (iv) *adequate ventilation and light; and*
 - (v) *a means of summoning aid; and*
 - (h) *the administration of any prescribed medications to the patient must not be unreasonably denied or delayed; and*
 - (i) *the patient must not be deprived of physical aids except as may be strictly necessary for the patient's safety or the preservation of those physical aids for the patient's future use; and*
 - (ia) *the patient must not be deprived of any communication aid that the patient uses in communicating on a daily basis, except as may be strictly necessary for the patient's safety or the preservation of the communication aid for the patient's future use; and*
 - (j) *regardless of authorisation, the restraint must not be maintained to the obvious detriment of the patient's mental or physical health.*
- (3) *Nothing in this section is to be taken as conferring any kind of authority for a patient to be placed under restraint as a means of punishment or for reasons of administrative or staff convenience.*
- (4) *However, nothing in this section applies to or prevents the emergency short-term physical restraint of a patient, subject to and in accordance with relevant CCP standing orders or clinical guidelines, so as to –*
- (a) *prevent the patient from harming himself or herself or others; or*
 - (b) *prevent the patient from damaging, or interfering with the operation of, a facility or any equipment; or*

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(c) break up a dispute or affray involving the patient; or

(d) ensure, if he or she is uncooperative, the patient's movement to or attendance at any place for a lawful purpose.

(5) Notwithstanding the discretionary nature of the power under section 152(1), the CCP must ensure that standing orders are issued for this section.

(6) In this section—

prescribed reason, for placing a patient under restraint, means —

(a) to facilitate the patient's treatment; or

(b) to ensure the patient's health or safety; or

(c) to ensure the safety of other persons; or

(d) to effect the patient's transfer to another facility, whether in this State or elsewhere.

Note 1: The restraint of an involuntary patient is reviewable by the Tribunal – see Division 2 of Part 3 of Chapter 3.

Note 2: The CCP has power to intervene in such circumstances – see section 147.

58. Records, &c.

(1) This section applies if an involuntary patient who is not a forensic patient is placed in seclusion or under restraint under this Part.

(2) The person who authorises the seclusion or restraint is to —

(a) make an appropriate record of the matter; and

(ab) give a copy of the record to the patient, together with a statement of rights in a CCP approved form; and

(b) give a copy of the record to the CCP and the Tribunal; and

(c) place a copy of the record on the patient's clinical record.

(3) The CCP or Tribunal, by notice, may require the treating medical practitioner to provide further information about the matter within a required time and the treating medical practitioner is to comply with that requirement.

Schedule 1

1. The mental health service delivery principles are as follows:

(a) to respect, observe and promote the inherent rights, liberty, dignity, autonomy and self-respect of persons with mental illness;

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- (b) to interfere with or restrict the rights of persons with mental illness in the least restrictive way and to the least extent consistent with the protection of those persons, the protection of the public and the proper delivery of the relevant service;*
- (c) to provide a service that is comprehensive, accessible, inclusive, equitable and free from stigma;*
- (d) to be sensitive and responsive to individual needs (whether as to culture, language, age, religion, gender or other factors);*
- (e) to emphasise and value promotion, prevention and early detection and intervention;*
- (f) to seek to bring about the best therapeutic outcomes and promote patient recovery;*
- (g) to provide services that are consistent with patient treatment plans;*
- (h) to recognise the difficulty, importance and value of the role played by families, and support persons, of persons with mental illness;*
- (i) to recognise, observe and promote the rights, welfare and safety of the children and other dependants of persons with mental illness;*
- (j) to promote the ability of persons with mental illness to make their own choices;*
- (k) to involve persons receiving services, and where appropriate their families and support persons, in decision-making;*
- (l) to recognise families, and support persons, of persons with mental illness as partners, with mental health service providers, in the provision of their treatment and care to the extent that this is appropriate and consistent with their own wishes;*
- (m) to respect the wishes of persons receiving services, and the wishes of their families and support persons, to the maximum extent consistent with the health and safety of those persons and the safety of others;*
- (n) to promote and enable persons with mental illness to live, work and participate in their own community;*
- (o) to operate so as to raise community awareness and understanding of mental illness and to foster community-wide respect for the inherent rights, liberty, dignity, autonomy and self-respect of persons with mental illness;*
- (p) to be accountable;*
- (q) to recognise and be responsive to national and international clinical, technical and human rights trends, developments and advances.*