Chemical Restraint

Chief Forensic Psychiatrist Standing Order 10

Provisions to Which the Order Relates

Mental Health Act 2013 – sections 3, 6, 11, 15, 92, 95, 96 and Schedule 1.

Preamble

1. Chemical restraint is one of the most restrictive options available to staff in managing the behaviour of involuntary patients in approved hospitals.
2. An involuntary patient may only be chemically restrained if the chemical restraint is authorised by the Chief Forensic Psychiatrist or delegate pursuant to section 95 of the *Mental Health Act 2013* and only when necessary to:
   a. Facilitate the patient's treatment, or
   b. Ensure the patient's health or safety or the safety of other persons, or
   c. Effect the patient's transfer to another facility, whether in Tasmania or elsewhere.
3. Patients who are chemically restrained must be examined in accordance with section 95 of the *Mental Health Act 2013* and must be provided with suitable clean clothing and bedding, adequate sustenance, adequate toilet and sanitary arrangements, adequate ventilation and light and a means of summoning aid while being restrained.
4. The administration of any prescribed medication to a patient who is chemically restrained must not be unreasonably denied or delayed.
5. Patients who are chemically restrained must not be deprived of physical aids or communication aids that the patient uses in communicating on a daily basis, except as may be necessary for the patient's safety or the preservation of those aids for the patient's future use.
6. The person who authorises restraint is to make an appropriate record of the matter and is to give a copy of the record to the patient, to the Chief Forensic Psychiatrist and to the Mental Health Tribunal, or cause a copy of the document to be given to these people/bodies.
7. The actions referred to in paragraph 6 are to be taken as soon as practicable after the restraint is authorised.
8. 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".
9. Chemical restraint is not a form of treatment and should not be treated as such.

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10. 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.

11. The general intent and objectives of the *Mental Health Act* are clear – the provision of treatment and care 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.

12. 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.

Purpose

This Standing Order directs controlling authorities, medical practitioners, nurses and other secure mental health unit staff members in the chemical restraint of forensic patients under the *Mental Health Act 2013*, and related matters.

The Order 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 Standing Order is not an offence but may, particularly if it leads to unfavourable patient outcomes that might otherwise have been avoided or if there is a history of such disregard, constitute proper grounds for instigating professional or occupational disciplinary action against that individual.

Direction

I, Professor Kenneth Clifford Kirkby, being and as the Chief Forensic Psychiatrist, pursuant to sections 152 and 153 of the *Mental Health Act 2013* and section 22 of the *Acts Interpretation Act 1931* hereby:

Revoke all previous directions (standing orders) issued under section 152 of the *Mental Health Act 2013* with respect to the exercise of responsibilities relating to the chemical restraint of forensic patients with effect from 11.59 pm on 30 June 2017; and

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Issue the following direction (standing order) to controlling authorities (and delegates), authorised persons and other secure mental health unit staff members exercising responsibilities in relation to the chemical restraint of forensic patients under the *Mental Health Act 2013*, and related matters, with effect from 12.00 am on 1 July 2017:

1. Treatment of acute agitation syndromes should be administered according to the same standing orders and guidelines as are applicable for chemical restraint.
2. The decision to chemically restrain a patient must only be made after less restrictive interventions and de-escalation techniques have been tried without success, or when these have been considered but excluded as inappropriate or unsuitable in the circumstances.
3. Chemical restraint must never be applied as a means of punishment or to compensate for or overcome inadequate facility design, insufficient numbers of staff or inadequate qualifications or status of staff members on duty at the relevant time.
4. Chemical restraint of any forensic patient must be authorised by the Chief Forensic Psychiatrist or a delegate.
5. The Chief Forensic Psychiatrist or delegate is only to authorise chemical restraint if he or she has received satisfactory answers to the following questions:
    a. What de-escalation has been implemented?
    b. Has "time out" been attempted?
    c. Has pro re nata (PRN) medication been offered?
    d. Has 1:1 nursing been attempted?
    e. Have other staff who may have rapport with the patient been sourced to attempt de-escalation?
    f. How long is the restraint expected to last for and what criteria will be used to determine whether the restraint should be ceased?
    g. What is the post-restraint plan?
6. The decision to chemically restrain a patient is only to be made following a full risk assessment.
7. Each occasion on which medication is administered to chemically restrain a patient must be viewed as a new occasion of chemical restraint with full consideration given to less restrictive options and performance of a new risk assessment prior to authorisation being given.
8. Authorisation is to be obtained at the time that the decision to restrain a patient is made; authorisation must not be given in advance or conditional upon certain events occurring.
9. Authorisation is only to be given over the phone or via email if:

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a. The person giving the authorisation is satisfied, from the information given to him or her by members of nursing staff present with the patient at the relevant time, that the patient meets the criteria to be chemically restrained within the parameters set out in the *Mental Health Act 2013*, and

b. There is nobody else who could authorise the patient's chemical restraint in person within a time period that is consistent with the need to apply chemical restraint.

10. Forensic patients who are chemically restrained must be continually observed at all times by a registered nurse or medical practitioner. The focus of the observation must be on the person's safety and dignity and on any change in the person's physical or mental health status. Observation must be direct and in person and must not involve observation via video monitoring systems or similar technologies.

11. A patient is only be subjected to chemical restraint for a period of more than seven **(7)** hours if:

a. The patient has been examined by a medical practitioner within seven **(7)** hours of the restraint having commenced, and the medical practitioner has recommended that the restraint be conducted, and

b. The patient's restraint for this extended period has been authorised by the Chief Forensic Psychiatrist or a delegate, in advance.

12. A medical practitioner who examines a patient who is being chemically restrained to determine whether the restraint should continue for a period of more than seven **(7)** hours is only to recommend that the restraint be continued if the benefits associated with continuing the restraint are considered to outweigh the detriments and if continuing the restraint would not be detrimental to the patient's health or safety.

13. A patient who is still subject to the effects of chemical restraint twelve **(12)** hours after the restraint was applied, or who has been chemically restrained for a period of time which exceeds or is likely to exceed twelve **(12)** hours, must be examined by an approved medical practitioner prior to the expiry of the twelve **(12)** hour period.

14. Any use of chemical restraint must be in accordance with Chief Forensic Psychiatrist Clinical Guidelines and with the policies and procedures of the relevant secure mental health unit.

15. Matters relevant to the use of chemical restraint must be documented using Chief Forensic Psychiatrist Approved Form 10: Restraint. These must be completed as soon as practicable after the decision to chemically restrain the patient is made.

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16. A copy of the completed form must be forwarded to the Chief Forensic Psychiatrist by no later than the close of business on the first business day following the day on which the restraint was authorised.

17. The rationale for chemical restraint including the outcome of the risk assessment performed prior to the decision to chemically restrain must be clearly documented in the patient's clinical record and discussed with the patient's treating medical practitioner/approved medical practitioner.

18. Incidents leading to the application of chemical restraint must be logged via the incident management systems in place at the relevant time within the secure mental health unit.

19. A monthly report on the use of chemical restraint within secure mental health units is to be provided to the Chief Forensic Psychiatrist by no later than the 20th day of the month after the month in which the restraint was used.

Professor Kenneth Clifford Kirkby

Chief Forensic Psychiatrist

Date: 1 July 2017