Australian Health Ministers' Advisory Council
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Mental Health, Drug and Alcohol Principal Committee
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Safety and Quality Partnership Standing Committee

National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services

Developed by the Restrictive Practice Working Group

Endorsed by the Mental Health Drug and Alcohol Principal Committee on 15 December 2016

Preamble

Restrictive practices are a last resort and the dignity and rights of people accessing mental health services should be respected and supported at all times.

Reducing, and where possible eliminating, restrictive practices in mental health services has been a key national mental health safety and quality priority[1]. After more than ten years of reduction activities and in response to sector expectations, these national high level principles aim to establish a consistent best practice approach to support the goal of eliminating the use of mechanical and physical restraint by mental health services. It is envisaged the principles will guide and support the development and review of detailed jurisdictional operational guidelines as appropriate across a range of service settings.

The principles are intended to apply to all mental health services in Australia. They can be adapted to local circumstances however, they are not mandated so should be used in conjunction with state or territory policy on restrictive practices. Where there is inconsistency, local policy and legislation has precedence.

Restraint Definitions

In October 2014 the Australian Health Ministers' Advisory Council endorsed national definitions for mechanical and physical restraint in mental health services.

Restraint:
The restriction of an individual's freedom of movement by physical or mechanical means.

Mechanical Restraint:
The application of devices (including belts, harnesses, manacles, sheets and straps) on a person's body to restrict his or her movement. This is to prevent the person from harming him/herself or endangering others or ensure the provision of essential medical treatment. 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 where the devices are used solely for the purpose of restraining a person's freedom of movement. The use of a medical or surgical appliance for the proper treatment of physical disorder or injury is not considered mechanical restraint.

Physical Restraint:
The application by health care staff of hands-on immobilisation or the physical restriction of a person to prevent the person from harming him/herself or endangering others or ensure the provision of essential medical treatment.

[1] *National safety priorities in mental health: a national plan for reducing harm* (2005)
National Standards for Mental Health Services (2010)

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Recovery and trauma-informed practice

- Recovery principles, as outlined in *A national framework for recovery-oriented mental health services: Policy and theory*, should underpin all mental health service delivery.
- The adoption of recovery and trauma-informed principles empowers people throughout their recovery process and assists services to reduce and eliminate the use of restrictive practices.
- Mechanical and physical restraints are known to hinder recovery and traumatise or re-traumatise people; however, restraint may be necessary in some circumstances to ensure safety.
- To implement recovery and trauma-informed practices, mental health services manage a range of tensions including: maximising choice; supporting positive risk taking; allowing dignity of risk; complying with medico-legal requirements; exercising duty of care; and promoting safety.

Prevention strategies

- Provide convenient and early access to mental health services, including access to 24-hour assessment.
- Develop respectful relationships, rather than control and compliance.
- Maximise the availability of spaces and sensory options within inpatient facilities.
- When clinicians recognise that a person is becoming distressed or aggressive or when a person reports feeling this way, local procedures should support clinicians to intervene promptly and take a problem solving, flexible and therapeutic approach.
- Have safe medication administration guidelines.
- All policies, guidelines and local procedures should be person-centred, using trauma informed language and written and reviewed collaboratively with consumers and carers.
- Jointly develop recovery and wellbeing plans; recovery workbooks or Advance Directives; and early warning sign/relapse signature plans.
- Make joint or supported decisions with people about risk management and safety, including consideration of sensory modulation strategies to manage distress/arousal.
- Include family and carers in opportunities for positive risk taking and learning, including reviews of incidents.

Managing escalating behaviours

- Recognise individual signs of distress/arousal, from jointly developed wellness or personal safety plans.
- Clearly, respectfully communicate with the person, focussing on assisting the person to return to a calmer state.
- Use calming strategies, especially those identified by the person as helpful.
- Clear, respectful communication is essential at all times, even if the person reaches a level of agitation where harm to themselves or others is imminent or actual.
- Choose the least restrictive treatment intervention possible by considering whether an intervention:
    - increases or decreases the person's ability to self-regulate and self-manage their emotions and behaviour
    - respects the person's choice, values and preferences
    - enables the person to perform as many life skills as possible and connect with their regular life
    - maximises the person's connection with close relationships, support networks and community
    - augments the person's positive sense of self and draws upon their strengths
    - offers opportunities for a person to learn new skills, maximise their potential or connect with their inherent strengths.

During restraint

- If all other options have been exhausted and the decision to physically restrain a person is made, procedures should be followed for the least restrictive, shortest possible intervention necessary.
- Restraint should only be carried out by appropriately trained staff using the safest techniques possible.
- One staff member should be identified as the lead for assisting the person to return to a calmer state.
- Acknowledge and validate the individual's distress and provide ongoing reassurance.
- Avoid the prone restraint position wherever possible and if there is no alternative, limit the time prone restraint occurs to the minimum amount of time necessary to safely change position.

Post restraint

- An episode of restraint can be traumatic; following any incident of restraint, support strategies should be available for the person, staff, patients, carers and/or family members who witnessed the event, and any others as appropriate (for example family members informed about the event).
- Debriefing and review processes are essential; the purpose and benefits should be explained to the person and anyone else affected by the event. However the person should not be coerced into a debriefing session. If the person wishes to discuss an incident at a future time, this should be facilitated.
- Peer workers or carer consultants should be engaged in debriefing and review processes.
- Services should have open disclosure practices, be trauma-informed and be timely in following up after an incident has occurred. Review process for all incidents of restraint should look at individual incidents and groups of incidents to determine any individual and or systemic changes to practice.

Partnerships

- The development and review of response plans should include consultation with relevant clinical and non-clinical staff (including safety and security staff), consumers, carers and external agencies such as police.
- Police assistance may be included in response plans with a determination of who makes the decision to seek police assistance.
- Processes should be established for the review of incidents involving other services, including first responders and transport service providers such as ambulance services; aeromedical retrieval services; police; security agencies and correctional services. Comprehensive interagency agreements can formalise the role and responsibilities for the assessment and treatment of people to utilise the least restrictive approach.

Training

- The principles underpinning training should be standardised across services, competency-based, provided at orientation and at regular intervals thereafter.
- Training should be developed, delivered and evaluated in partnership with consumer, carer and peer workers.
- As a minimum, staff should be trained in:
    - prevention and early intervention strategies with a strong emphasis on verbal and other non-physical strategies, communication and customer service
    - non-coercive therapeutic crisis intervention
    - safe, standardised physical restraint as a last resort
    - reflection skills and how to continue to learn from situations, to further develop skills over time, particularly to avoid situations reoccurring.
- Other potential training to consider includes:
    - trauma-informed care
    - sensory modulation
    - mindfulness
    - debriefing.

Data

- Data collection and reporting systems should be informing quality improvement and benchmarking activities locally and nationally.
- Data collection for specialised mental health public hospital acute service units should be consistent with the requirements of the Mental Health Seclusion and Restraint Data Set Specification.

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