# Practice Guidance and Reporting Flowchart – Restrictive interventions in emergency departments (EDs) and urgent care centres (UCCs)

**Under the *Mental Health and Wellbeing Act 2022* (the Act), the Chief Psychiatrist's oversight of restrictive interventions is extended beyond people receiving compulsory assessment and treatment to also encompass any person receiving mental health and wellbeing services in EDs and UCCs in designated mental health services (DMHS). This includes people who present voluntarily even in circumstances where consent is unclear.**

## Is this person receiving a mental health and wellbeing service?

A mental health and wellbeing service means a professional service performed for the primary purpose of -

- improving or supporting a person's mental health and wellbeing; or
- assessing, or providing treatment, care or support to, a person for mental illness or psychological distress; or
- providing care or support to a person who is a family member, carer, or supporter, of a person with mental illness or psychological distress (examples below are not exhaustive).

Being brought under the care and control of police with or without ambulance services for a mental health examination under s 232 of the Act (similar to the previous Act's s 351 powers)

Voluntarily seeking mental health support

Being brought in by a family member or friend for a mental health assessment and/or support (e.g. parents bringing in a child)

A compulsory patient awaiting a bed in an inpatient mental health unit (e.g. a patient is placed on an assessment order in the community or someone on a Community Treatment Order (CTO) is varied to an inpatient Treatment Order (TO))

Presenting initially with a non-mental health condition but subsequently being assessed as requiring a mental health and wellbeing service

## Principles and proper considerations of decision-making

The Act's principles require all consumers and carers to be treated with respect and dignity.

Care is to be given in the least restrictive way reasonably possible. Medical and other health needs are to be accommodated and diverse needs are to be actively considered.

Furthermore, gender safety and cultural safety are to be given priority, and families, carers and supporters are to be included. Consumers must be supported to make decisions and to be involved in decisions about their assessment, treatment and recovery.

Consumers, families, carers and supporters, where appropriate, should be consulted on their valuable and useful insights that may be helpful in preventing a restrictive intervention.

Proper consideration must be given to decision-making principles in the Act before and during a restrictive intervention. There are 5 such principles relevant to restrictive interventions in EDs and UCCs:

- no therapeutic benefit to restrictive interventions principle (s 81)
- balancing the harm principle (s 82)
- autonomy principle (s 83)
- care and transition to less restrictive support principle (s 79)
- consequences of compulsory assessment and treatment and restrictive interventions principle (s 80)

The person authorising the restrictive intervention must consider the person's views of, and preferences relating to, the use of restrictive practices; the views and preferences expressed in any advance statement of preferences (ASP- check CMI/ODS) of the person and the views of any nominated support person (NSP). [Note that a registered nurse authorising (urgent) physical restraint does not have to give regard to an ASP or the NSP s 132 (5)]

Once a practitioner has begun their consideration of whether to authorise a restrictive intervention, the obligations of the Act apply

**Are restrictive interventions only being used as a last resort after all reasonable and less restrictive options have been tried or considered?**

May only be used to prevent imminent and serious harm to that person or another person or in the case of bodily restraint to administer treatment or medical treatment

**No** → Pursue all reasonable and less restrictive options

**Yes**

### Bodily Restraint

**Physical**

**Authorisation**
Document on MHWA 140 or 141 form

**Mechanical**

**Authorisation**
Document on MHWA 140 form

Bodily restraint must be authorised by an authorised psychiatrist, or if they are not reasonably available, a registered medical practitioner or a nurse in charge.

Chemical restraint may only be authorised by an authorised psychiatrist; or if an authorised psychiatrist is not reasonably available, a registered medical practitioner or a nurse practitioner acting within their ordinary scope of practice.

The authorisation must be completed on either the MHWA 140 - Authority for use of restrictive interventions or MHWA 143 - Authority for use of chemical restraint.

**Monitor continuously - by registered nurse or registered medical practitioner**

Observe and document minimally every 15 mins for duration on MHWA 142 form - Restrictive interventions observations

**Examination - by authorised psychiatrist or registered medical practitioner**

As soon as practicable and then as often as is appropriate but not less frequently than every 4 hours

If the person who authorises a restrictive intervention is not an authorised psychiatrist, they must notify the authorised psychiatrist as soon as practicable after the authorisation.

Confirmation relevant people, as listed in the notes section of the MHWA forms 140, 141 and 143 under 'Notifications', have been notified of the use of the restrictive intervention

A registered nurse may authorise physical restraint on a person if an authorised psychiatrist, registered medical practitioner or nurse in charge is not immediately available. Document on MHWA 141 - Authority for urgent physical restraint

End the restrictive intervention as soon as possible; offer post restrictive intervention support; where practicable offer an experience of care review

**Has this restrictive intervention taken place in a DMHS?**

**Yes**

**CMI/ODS data entry**

Monthly reporting by Authorised Psychiatrist to OCP (10th of the month)

Triggers automatic IMHA notification

**No**

**Not reportable to OCP**

Use of documentation above allows a non designated mental health service to demonstrate best practice but there is no obligation to report to OCP

### Pharmacological approaches

Establish primary purpose of the medication administration

Is the primary purpose of medication administration to control the person's behaviour by restricting their freedom of movement?

**Yes**

**Chemical Restraint**

**Authorisation**
Document on MHWA 143 form

**Monitor continuously - by registered nurse or registered medical practitioner**

For a minimum of 1 hour and then as clinically appropriate: document minimally every 15 mins on MHWA 142 form

**Examination - by authorised psychiatrist or registered medical practitioner**

As soon as practicable and then as often as is appropriate but not less frequently than every 4 hours

**Seclusion** is regulated under the Act but is **not permitted** in Emergency Department's

**No**

Primary purpose is for treatment (for mental illness) or medical treatment

Monitor as per local guidance; document in medical record

**Not reportable to OCP**

## LEGEND

| | |
|---|---|
| **MHWA/the Act** | Mental Health and Wellbeing Act 2022 |
| **DMHS** | Designated Mental Health Service |
| **CMI/ODS** | Client Management Interface and Operational Data Store |
| **IMHA** | Independent Mental Health Advocacy |
| **OCP** | Office of the Chief Psychiatrist |
| **RI** | Restrictive Interventions |

## RIGHTS AND ADVOCACY

All people receiving a mental health and wellbeing service at a DMHS are entitled to a statement of rights.

All people receiving a mental health and wellbeing service at a DMHS are also entitled to make a complaint directly to a mental health and wellbeing service provider or to the Mental Health and Wellbeing Commission.

Any person subject to a compulsory assessment or treatment order OR a restrictive intervention are entitled to opt-out non-legal advocacy services (provided by IMHA).

The role of a nominated support person includes, but is not limited to, advocating for the views and preferences of the consumer including preferences provided in the advance statement of preferences (see s 61 for further details).

Use in conjunction with ***OCP's factsheet and summary on RI in EDs and UCCs*** <https://www.health.vic.gov.au/chief-psychiatrist/office-of-the-chief-psychiatrist-re-form-activities-and-news>, and ***RI guideline and reporting directive*** <https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions>

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