

Factsheet – Restrictive interventions in emergency departments and urgent care centres of designated mental health services

Office of the Chief Psychiatrist

OFFICIAL

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Summary

From 1 April 2024 the Office of the Chief Psychiatrist will oversee the use of restrictive interventions once a person is receiving a mental health and wellbeing service in the emergency department (ED) or urgent care centre (UCC) of a designated mental health service.

Through this change, the oversight of restrictive interventions under mental health legislation is extended beyond people subject to compulsory assessment and treatment orders to also encompass

people who present voluntarily or are brought by others. This includes people brought to EDs and UCCs in the care and control of police with or without Ambulance Victoria's assistance.¹

The legal basis for the change is set out in the *Mental Health and Wellbeing Act 2022* (the Act), which expands the regulation of restrictive interventions to a broader range of circumstances and strengthens the safeguards of people subjected to a restrictive intervention.

The Act's provisions on restrictive interventions in EDs and UCCs mean new compliance requirements for staff in those settings. These new provisions focus on human rights and reporting restrictive interventions to the Office of the Chief Psychiatrist.

Designated mental health services

A designated mental health service is an entity listed in the definition in the Act or in Schedule 1 of the Mental Health and Wellbeing Regulations 2023 (the Regulations).

The following services are currently listed as designated mental health services:

- Albury Wodonga Health
- Alfred Health
- Austin Health
- Barwon Health
- Bendigo Health Care Group
- Eastern Health
- Goulburn Valley Health
- Grampians Health
- Latrobe Regional Hospital
- Melbourne Health
- Mercy Public Hospitals Incorporated
- Mildura Base Public Hospital
- Monash Health
- Northern Health
- Peninsula Health
- Royal Children's Hospital
- South West Healthcare
- St Vincent's Hospital (Melbourne) Limited
- Victorian Institute of Forensic Mental Health (Forensicare)
- Western Health.

This list may be updated periodically as services are prescribed as a designated mental health service in the Regulations.

If your health service is not on this list, it is not currently a designated mental health service. A restrictive practice that occurs in a service not prescribed as a designated mental health service is not reportable to the Chief Psychiatrist, even when it involves a person on a compulsory order (defined in the Act as a 'patient').

Definition of a mental health and wellbeing service

In Part 1.2.3 of the Act, 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.

¹ Victoria Police and Ambulance Victoria are not mental health and wellbeing service providers and therefore do not report to the Chief Psychiatrist.

Determining when a person is receiving a mental health and wellbeing service in an ED or UCC

In the context of EDs and UCCs in a designated mental health service, the circumstances when a person is receiving a mental health and wellbeing service and the Act's provisions apply include:

- being brought under the care and control of police with or without ambulance services for a mental health examination under s 232 of the Act² (similar to the previous Act's s 351 powers), once care and control has been transferred to the assessing clinician
- 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.³

The above examples are not exhaustive but illustrate that the person has attracted a professional service for the purpose of 'assessing, or providing treatment, care or support to a person for mental illness or psychological distress' (Part 1.2.3 of the Act). Once a practitioner has begun their consideration of whether to authorise a restrictive intervention, the obligations of the Act apply.

When a person is considered to no longer require a mental health and wellbeing service, the lawful basis of the restrictive intervention under this Act has ended. It is no longer reportable to the Chief Psychiatrist.

Restrictive interventions

The Act defines a restrictive intervention to mean 'seclusion, bodily restraint or chemical restraint' (s 3(1)), whereby:

- **Seclusion** means 'the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave' (**seclusion is not permitted in EDs**).
- **Bodily restraint** means 'physical restraint, or mechanical restraint, of a person'.
 - **Physical restraint** means 'the use by a person of their body to prevent or restrict another person's movement but does not include the giving of physical support or assistance to a person in the least restrictive way that is reasonably necessary to—
 - enable the person to be supported or assisted to carry out daily activities; or
 - redirect the person because they are disoriented'.
 - **Mechanical restraint** means 'the use of a device to prevent or restrict a person's movement'.
- **Chemical restraint** means 'the giving of a drug to a person for the primary purpose of controlling the person's behaviour by restricting their freedom of movement but does not include the giving of a drug to a person for the purpose of treatment or medical treatment'.

Section 125 of the Act specifies that mental health and wellbeing services should aim to reduce the use of restrictive interventions and eventually eliminate restrictive interventions in mental health treatment. This is inclusive of EDs and UCCs.

² For the purpose of referencing the Act, the convention of abbreviating sections with 's' will be used in this document.

³ This is not an exhaustive list and has been compiled to highlight the types of mental health and wellbeing service provision that are typical to an ED or UCC setting.

Restrictive interventions as a last resort

Restrictive interventions may only be used as a last resort, after all reasonable and less restrictive options have been tried or considered.

Specifically, restrictive interventions may *only* be used in respect of a person:

- to prevent imminent and serious harm to that person or another person (s 127 (a)), or
- in the case of bodily restraint – to administer treatment (as defined in s 5) or medical treatment to the person (s 127(b))
- if necessary to achieve the purposes specified in s 127 (s 128(1)), and if all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable (s 128(2)).

Chemical restraint

When determining what is chemical restraint within the meaning of this Act and is therefore reportable to the Chief Psychiatrist, consider these 4 questions:

1. Is this practice taking place in a designated mental health service?
2. Is the person receiving a mental health and wellbeing service (as outlined above)?
3. Is there a permitted reason for this practice? That is, to prevent imminent and serious harm to that person or another person.
4. Is the primary purpose of the 'giving of a drug' to control behaviour by restricting freedom of movement?

If the answer to *all* these questions is 'yes', the practice constitutes chemical restraint and is therefore reportable to the Chief Psychiatrist.

The new Mental Health and Wellbeing Act

On 1 September 2023 the *Mental Health Act 2014* was replaced with the *Mental Health and Wellbeing Act 2022*. This development of a new Act was a key recommendation of the Royal Commission into Victoria's Mental Health System.

The Act brings into existence new provisions for protecting the rights of people receiving a mental health service and ensuring restrictive interventions are only ever used as a last resort.

The Act also defines chemical restraint in Victorian legislation for the first time and classes it as a form of restrictive intervention, thereby subjecting it to the same safeguards and oversight that exist for other forms of restrictive interventions.

A regulation was made to defer implementing the Act's provisions on restrictive interventions in EDs and UCCs for seven months to give services in these settings enough time to prepare for the changes to clinical practice and governance.

From 1 April, these provisions will come into force in EDs and UCCs in designated mental health services, aligning legislation on restrictive interventions there with the rest of Victoria's mental health and wellbeing system.

What does this change mean for EDs and UCCs?

All staff working in EDs and UCCs in a designated mental health service must comply with the legal requirements set out in the Act when using a restrictive intervention on people receiving a mental health and wellbeing service.

Principles

The Act contains mental health and wellbeing principles to guide service providers, including staff in EDs and UCCs, in upholding the dignity and autonomy of people living with mental illness or psychological distress.

The mental health and wellbeing principles require 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 in making decisions on their treatment and care.

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), particularly for those with diverse needs including young people, older people, Aboriginal people, culturally and linguistically diverse people and those with intellectual disability or acquired brain injury.

Other consideration must be given to, as outlined in s 131 of the Act:

- an Advance Statement of Preferences (ASP) if one exists (check CMI-ODS)
- the likely impact on the person of any restrictive intervention, particularly with regard to past experiences of trauma
- the views of the person and their nominated support person.

Authorisation of restrictive interventions

Restrictive interventions must be authorised by an authorised psychiatrist, or if they are not reasonably available, a registered medical practitioner or a nurse in charge (s 132). In the instance of chemical restraint, authorisation may also be from a nurse practitioner acting within their ordinary scope of practice, if an authorised psychiatrist is not reasonably available.

In an ED, the emergency medicine consultant or registrar is likely to be the authorising person in the first instance. In a UCC, a registered nurse or general practitioner is likely to be the authorising person in the first instance. 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. What is practicable will be determined on a service by service basis.

The authorisation of restrictive interventions must be completed on one of the two following forms:

- MHW 140 Authority for use of restrictive interventions
- MHW 143 Authority for use of chemical restraint.

The use of an 'MHW 141 Authority for urgent physical restraint' form in an ED is likely to be rare.

Monitoring restrictive interventions

A person who is subjected to a restrictive intervention must be monitored in line with s 137 of the Act. Monitoring involves a combination of functions that include observation, clinical review and examination. A summary of these monitoring requirements is outlined in the table over the page. An MHW 142 restrictive interventions observation form is designed to reflect these monitoring requirements.

Summary of monitoring requirements during restrictive interventions with reference to the relevant section of the Act

Restrictive intervention	Requirement	Duration	Frequency	By whom
Bodily restraint (includes mechanical) s 137(2)(a)	Continuously observe	Ongoing for entire period of restraint		Registered nurse or registered medical practitioner
Chemical restraint s 137(2)(b)	Continuously observe	Ongoing for not less than 1 hour after chemical restraint is administered		Registered nurse or registered medical practitioner
Bodily restraint (includes mechanical) s 137(3)	Clinically review		As often as is appropriate, having regard to the person's condition, but not less frequently than every 15 minutes	Registered nurse or registered medical practitioner
Chemical restraint s 137(3)	Clinically review		As often as is appropriate, having regard to the person's condition, but not less frequently than every 15 minutes	Registered nurse or registered medical practitioner
All restrictive interventions s 137(4)	Examine		As often as is appropriate, having regard to the person's condition, but not less frequently than every 4 hours	Authorised psychiatrist. If not practicable for an authorised psychiatrist to conduct an examination at the frequency that the authorised psychiatrist is satisfied is appropriate, the person may be examined by a registered medical practitioner when directed by the authorised psychiatrist (s 137(5)).

Source: Adapted from the *Chief Psychiatrist's guideline on restrictive interventions*.

Clinical documentation

An authorised psychiatrist, registered medical practitioner, nurse practitioner, nurse in charge or registered nurse is required to document the following matters as soon as practicable after a restrictive intervention is authorised (s 133):

- the reason the restrictive intervention is necessary
- all the other less restrictive means tried or considered for the person in trying to achieve the purpose of the restrictive intervention (e.g. administering medication, using support people such as a peer support worker)

- the reasons why those less restrictive means were unsuitable.

The following matters should also be documented on the person's clinical record:

- any attempts made to communicate with the person, listen to their requests and consult with or contact their families, carers and supporters and/or nominated support person to avoid using a restrictive intervention
- a description of the person's condition at the start of the intervention
- details arising from the nursing observations and clinical reviews
- any medication or other treatment provided and the response to treatment
- the outcome of the initial and 4-hourly medical examinations
- a copy of the completed MHW 140, 141 or 143 authorisation form
- a copy of the completed MHW 142 restrictive interventions observation form
- confirmation relevant people have been notified of the use of the restrictive intervention under ss 134, 135 and 138 (as listed in the notes section of the MHW forms 140, 141 and 143 under 'Notifications')
- post-intervention support that was appropriate to this setting (see section, 'Post-restrictive intervention consumer support,' in the [Chief Psychiatrist's guideline on restrictive interventions](https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions) <https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions>).

Data entry into CMI-ODS

The health service must identify the person/position responsible for entering data into CMI-ODS for this expanded group of people that reporting is now required for. The Chief Psychiatrist does not have a view about whether this is best done by ED or mental health personnel. A discussion should take place with the Health Information Manager (HIM) to gain access permissions and relevant training.

The role of the Chief Psychiatrist

The Chief Psychiatrist oversees restrictive interventions in designated mental health services.

The Chief Psychiatrist is an independent statutory officer, with powers and responsibilities prescribed by the Act to uphold the quality and safety of clinical services in Victoria's mental health and wellbeing system. As part of their oversight and leadership role, the Chief Psychiatrist:

- monitors clinical service providers to ensure compliance with the Act
- investigates incidents when the safety or wellbeing of a person was endangered while receiving a mental health and wellbeing service
- reviews and audits service provision to find and resolve quality and safety issues
- publishes guidelines on clinical best practice
- promotes the rights of people receiving a mental health and wellbeing service.

Reporting to the Chief Psychiatrist

Authorised psychiatrists are responsible for submitting monthly restrictive intervention data to the Chief Psychiatrist via the [Office of the Chief Psychiatrist SharePoint portal](https://dhhs.vic.gov.au.sharepoint.com/sites/OCP) <https://dhhs.vic.gov.au.sharepoint.com/sites/OCP> by the 10th of the following month.

For detailed instructions to assist with reporting obligations, refer to [Chief Psychiatrist's reporting directive for restrictive interventions](https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions) <https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions>.

Staff in EDs and UCCs will assist the authorised psychiatrist in meeting their obligation by the timely and accurate completion of forms MHW 140, 141, 142 and/or 143.

Reporting noncompliance to the Chief Psychiatrist

The failure to comply with the new requirements on restrictive interventions is a breach of the Act. The authorised psychiatrist or their delegate must report this to the Chief Psychiatrist.

Relevant sections in the Act

- Part 3.7 Division 1, Sections 125 – 129: Use of restrictive interventions under this Act
- Part 3.7 Division 2, Sections 130 – 138: Use of restrictive interventions in a designated mental health service
- Part 3.7 Division 3, Section 139: Chemical restraint during transport

Practice guidelines and reporting directives

Information on best practice guidelines, reporting and notification obligations for mental health and wellbeing service providers is contained within the [Chief Psychiatrist's interim guideline for restrictive interventions](https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions) <https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions> (valid until 31 March 2024) and the [Chief Psychiatrist's reporting directive for restrictive interventions](https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions) <https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions>. An updated [Chief Psychiatrist's guideline for restrictive interventions](https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions) <https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions> will be available in March 2024 and take effect on 1 April 2024.

Further information

The Act is available for download from the [Victorian Legislation website](https://www.legislation.vic.gov.au/in-force/acts/mental-health-and-wellbeing-act-2022/001) <https://www.legislation.vic.gov.au/in-force/acts/mental-health-and-wellbeing-act-2022/001>.

eLearning modules on Mental Health and Wellbeing Act. Can access by creating account on [Mental Health Professional Online Development](https://elearning.mhpod.gov.au/) <https://elearning.mhpod.gov.au/> and then following this pathway from dashboard: Topic library > Jurisdiction specific topics > Victoria > Mental Health and Wellbeing Act 2022.

[Safewards](https://www.safercare.vic.gov.au/best-practice-improvement/improvement-projects/mental-health-wellbeing/safewards-victoria-trial) <https://www.safercare.vic.gov.au/best-practice-improvement/improvement-projects/mental-health-wellbeing/safewards-victoria-trial>

Queries relating to restrictive interventions can be emailed to the Office of the Chief Psychiatrist ocp@health.vic.gov.au.

To receive this document in another format, phone 1300 767 299, using the National Relay Service 13 36 77 if required, or email ocp@health.vic.gov.au

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

© State of Victoria, Australia, Department of Health, March 2024.

ISBN 978-1-76131-545-9 (online/PDF/Word)

Available at [Office of the Chief Psychiatrist – Reform activities and news](https://www.health.vic.gov.au/chief-psychiatrist/office-of-the-chief-psychiatrist-reform-activities-and-news) <https://www.health.vic.gov.au/chief-psychiatrist/office-of-the-chief-psychiatrist-reform-activities-and-news>