



## Chief Psychiatrist's Standards for Clinical Care

As required under Section 547 of the Mental Health Act 2014

### Standard: Seclusion and Bodily Restraint Reduction

The Mental Health Act 2014 requires the Chief Psychiatrist to be responsible for overseeing the treatment and care to a range of users of mental health services. The Chief Psychiatrist is required to discharge that responsibility by publishing a set of standards for treatment and care provided by Mental Health Services and overseeing compliance with those standards.

The Chief Psychiatrist of Western Australia has accepted two sets of standards as the overarching standards relevant for the Mental Health Act 2014.

- For clinical mental health services: [National Safety and Quality Health Service](#) (NSQHS) Standards.
  - Implemented from 1 November 2023
- For other mental health services: [National Safety and Quality Mental Health Standards for Community Managed Organisations](#) (NSQMHS for CMOs).
  - In the process of implementation. Until implementation is complete, the accepted standards remain the [National Standards for Mental Health Services](#).

In addition, the Chief Psychiatrist has published the Chief Psychiatrist's Standards for Clinical Care. These standards have been developed within the following context:

- The specific Chief Psychiatrist's Standards are not designed to replace the NSMHS but enhance them where local development is identified as needed.
- They cover certain areas the Chief Psychiatrist deems to be either of central importance or requiring local jurisdictional focus.
- They are designed to leverage quality clinical care and are purposefully and predominantly targeted towards clinical practice.
- They are designed to be easily and quickly read by clinicians, and also by consumers and carers - hence they are relatively brief, not exhaustive.

#### Version

<b>Purpose</b>	Statutory Requirement under the Mental Health Act 2014
<b>Relevant To</b>	All Mental Health Service Providers
<b>Approval Authority:</b>	Dr Nathan Gibson Chief Psychiatrist
<b>Effective Date:</b>	30 November 2015
<b>Responsible Group:</b>	Chief Psychiatrist Standards and Guidelines Working Group
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## Standard: Seclusion and Bodily Restraint Reduction

This Standard applies to all public and private mental health services as defined by the *Mental Health Act 2014*.

### Definition

1. **Seclusion:** is defined as confinement of a person, who is being provided with treatment or care at an authorised hospital, by leaving the person at any time of the day or night alone in a room or area from which it is not within the person's control to leave.<sup>1</sup>
2. **Bodily restraint:** is the physical or mechanical restraint of a person who is being provided with treatment or care at an authorised hospital.<sup>2</sup>
3. **Physical restraint:** is the application of bodily force to the person's body to restrict the person's movement.<sup>2</sup>
4. **Mechanical restraint:** is the application of a device, to restrict the person's movement, such as a belt, harness, manacle, sheet or strap. Mechanical restraint does not include either the appropriate use of medical or surgical appliances or the appropriate use of furniture to restrict a person such as cot sides or a chair fitted with a table. It also does not include physical or mechanical restraint by a police officer.<sup>2</sup>

### Purpose

Reduction of seclusion and restraint events, time spent in seclusion and trauma associated with seclusion and restraint.

### Context

Mental health services are never risk-free and clinical risks like suicide and violence cannot be predicted with 100% accuracy. Instead, good clinical risk management is based on effective treatment that is focused on an individual's history and current circumstances.<sup>2</sup>

1. Mental health services will endeavour to reduce the use of, and where possible, eliminate seclusion and restraint.
2. Seclusion and restraint are interventions not therapies.
3. Risk of trauma and physical harm to staff and patients can be increased by use of seclusion and restraint.
4. If and when pro re nata (as needed) medication is used, it should be judiciously administered for the purpose of calming and not sedating.
5. Where there are no appropriate alternatives to seclusion or restraint they should be administered in the most safe, dignified and respectful manner as possible by appropriately trained staff.
6. Restraint techniques will be standardised across all Authorised Hospitals to minimize error.

### Criteria

1. Management and staff of all Authorised Hospitals:
  - 1.1. Will comply with mental health legislation requirements relating to seclusion and restraint.

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<sup>1</sup> Mental Health Act 2014 Part 14 Division 5 & 6

<sup>2</sup> Australian Government (2010) National Standards for Mental Health Services

- 1.2. Will conduct, with all relevant staff, an approved age-appropriate training program for prevention of aggression and early intervention in a crisis situation. The training program will include the following elements:
  - 1.2.1. The majority of time will be focused on strategies such as de-escalation that prevent exacerbation of a crisis.
  - 1.2.2. The training program will incorporate trauma-informed care principles.
  - 1.2.3. Ongoing competency updates will include a training component undertaken in the ward environment.
  - 1.2.4. Peer Support Workers or persons with lived experience will contribute to the training wherever possible.
  - 1.2.5. There will be an explicit differentiation for staff between seclusion and timeout.
- 1.3. Will have a Sensory Modulation or equivalently named area and/or mobile sensory modulation equipment with an appropriate quiet space in which it can be used.
- 1.4. Will utilise a Patient Safety Plan (or equivalently named template identifying patient-driven strategies to prevent or reduce distress or agitation) drafted collaboratively between a patient and staff and where appropriate the carer, as soon as possible after admission.
- 1.5. Will debrief patients, relevant support persons and staff after seclusion and restraint events, and document this process.
- 1.6. Will not use neck holds.
- 1.7. Will avoid the use of prone restraint whenever possible to minimize the risk of respiratory compromise.
- 1.8. Will ensure monitoring and recording of physical observations and wellbeing during restraint.
- 1.9. Will, where appropriate and/or requested, advise the patient's carer, and/or personal support person of the seclusion and restraint event.
2. Medical staff will take a proactive role in seclusion and restraint minimisation:
  - 2.1. The Treating or Duty Psychiatrist will take an active leadership role in facilitating strategies for an individual patient that reduces seclusion and restraint.
  - 2.2. Medical staff will attend a clinical unit, at the earliest possible time, when there is evidence of escalating risk not settling with remote support.
  - 2.3. Medical staff will take an active decision making role early in the Seclusion and Restraint process.
3. Mental Health Units will hold a Service Executive Review of all seclusion and restraint events:
  - 3.1. Focusing on collaborative reduction, and not a blaming process.
  - 3.2. Held at least weekly with the staff involved in the seclusion and restraint events participating, whenever possible.
  - 3.3. Include the presence of a Peer Support Worker or individual with lived experience at the Review, whenever possible.
  - 3.4. Will publish local quarterly de-identified seclusion and restraint data at the service which is available to staff, patients and the general public.
    - 3.4.1. This data will be forwarded to the Chief Psychiatrist.

## Measures

1. Episodes of seclusions and restraint (per 1,000 bed days as denominator).
2. Designated time periods in seclusion and restraint.

## Future/Potential Measure

1. Compliance with the Service Executive Reviews of seclusion and restraint. This measure is under development.

## Acknowledgement

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[www.chiefpsychiatrist.wa.gov.au](http://www.chiefpsychiatrist.wa.gov.au).

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