Restrictive Practices Factsheet

Restrictive practices in this context refers to the use of restraint on, and/or detention of, a patient.

Key Principles

- Personal liberty is the most fundamental human right.
- Interference with a person's liberty is only permitted where it is justified, authorised or excused by law.
- Clinical situations are complex and specific to the patient, place, and time.
- The goal is to balance the rights and safety of the patient.
- All public officers are expected to exercise professional judgement and refuse a direction if they genuinely believe it to be unlawful (this includes the use of restrictive practices, misuse of public resources or any other unlawful activity).
- When decisions regarding restrictive practices are complex or uncertain, public officers are encouraged to escalate the matter for discussion with the appropriate delegated authority, where possible, in advance of the action taken.

Patient Rights

Patients admitted voluntarily to a hospital or health care facility have a right to refuse care or treatment and leave the hospital or health care facility at any time, unless the patient is incapacitated or presents an immediate risk to themselves, other patients, or staff.

Application of a restrictive practice should be a last resort after all reasonable and less restrictive options have been tried or considered, including de-escalation and distraction practices and processes.

Duty of Care

Duty of care does not provide the power to:

- restrain a person.
- prevent a voluntary patient from leaving a hospital.
- treat a voluntary patient who refuses treatment.

Duty of care is a legal obligation to take reasonable steps to not cause foreseeable harm to another person or their property.

Duty of care is upheld by clinicians when they provide patients with information on the risks of treatment; assess a patient's capacity to provide informed consent and treat patients according to the standards supported by their professions.

Doctrine of Necessity

Doctrine of Necessity is a common law doctrine, meaning it has been developed by the courts on a case-by-case basis. The defence of necessity requires the following:

1. The act was done to avoid immediate risk/harm to the person or others.
2. The person(s) carrying out the act did so from an honest and reasonable belief that the individual was placing themselves or others in a situation of immediate risk/harm.
3. The act was proportionate to the harm about to occur.

The Criminal Code (WA) - Emergency

Under section 25 of the Criminal Code, if a person acted in response to what they perceived to be a sudden and extraordinary emergency, and they believed their actions were necessary and reasonable, they may have a defence to any criminal charges relating to that situation.

When can the *Mental Health Act 2014* (MHA 2014) be used?

Completion of a Referral Order (Form 1A) under the MHA 2014 requires the completing clinician to have a **reasonable suspicion** that the person meets **all** the criteria for an involuntary treatment order, i.e. that they have a mental illness in need of treatment, that because of the mental illness there is a significant risk to health or safety, that they lack capacity, and that there is no less restrictive way to provide the treatment that is needed (s.25 MHA 2014). The grounds for the reasonable suspicion should be documented.

A patient who is referred on a Form 1A for examination by a psychiatrist is not at this stage involuntary, i.e. they retain the right to decline treatment. Under the MHA 2014 (s.202), Emergency Psychiatric Treatment (EPT) can only be provided if required to save a person's life, or to prevent the person behaving in a way that is likely to result in serious physical injury to themselves or another person. Restraint is not included within the definition of EPT. Use of EPT requires completion of a Form 9A, with a copy provided to the Chief Psychiatrist.

Pathways for Persons Referred for Examination under the MHA 2014

Form 1A	Referral Order (s.26)	Referral for examination by a psychiatrist (the place of examination may be an authorised hospital OR another place such as an ED)	Person **cannot** be restrained until received and detained at the place of examination
Form 3A	Detention Order (s.28)	Allows the person to be detained for 24 hours so they can be taken to place of examination	Person **cannot** be restrained
Form 3B	Continuation of Detention Order (s.28)	Detention can be extended for a further 24 hours up to 72 hours (metro) / 144 hours (non metro) so the person can be taken to place of examination	Person **cannot** be restrained
Form 1A	Referral Order (s.58)	Once received at place of examination, the person may be detained for 24 hours from the time received	Reasonable force may be used to prevent the person leaving
Form 3B	Continuation of Detention Order (s.59)	Once received at the place of examination, detention can be extended for a further 48 hours for the examination to occur if **outside the metro area**	Reasonable force may be used to prevent the person leaving
Form 4A	Transport Order (s.29)	Order to transport person to the place specified in the order	Person may be apprehended and reasonable force used by the **transport officer or police officer** to carry out the transport

When is the use of restraint lawful in a non-authorised setting?

In WA, most WA Health hospitals and healthcare facilities are non-authorised. The circumstances under which a patient may be legally restrained in a non-authorised setting include:

- with the valid consent of the patient
  - for a child (a person aged <18), consent may be provided by a child who is a mature minor, or by a parent/ guardian on the child's behalf if they are not a mature minor.
- under the MHA 2014
  - when a person has been referred for examination by a psychiatrist (Form 1A) AND has been received and detained at the place of examination identified on the Form 1A, in order to prevent them leaving that place;
  - when a person is an involuntary community patient on a Community Treatment Order AND is subject to an Order to Attend (Form 5F) AND is received and detained for up to 6 hours at the

place identified on the Form 5F in order to receive treatment, in order to prevent them leaving that place before receiving the treatment;
  - when a person, following examination by a psychiatrist, has been made an involuntary inpatient in a general hospital (Form 6B);
- for *urgent treatment* of patients (excluding psychiatric treatment of mental illness) who are unable to make treatment decisions for themselves and have an appointed guardian who provides consent; or in an emergency, under the *Guardianship and Administration Act 1990*;
- in situations to prevent immediate risk or harm (Doctrine of Necessity); or
- in situations of sudden or extraordinary emergency where the actions taken are reasonable (Criminal Code).

Consent and Capacity
- In urgent circumstances, robust assessment of capacity may not be possible.
- When assessing capacity in adults, it should be assumed that the patient does have capacity until assessment determines otherwise.
- For children (anyone < 18), it may be assumed that the patient does not have capacity unless they can demonstrate capacity
- For children, consent may be provided by:
  - The child if they are a mature minor, or;
  - A parent or guardian on behalf of a patient who is not a mature minor.

When is the use of restraint unlawful?
Other than in an immediate, grave emergency, there are very few circumstances in which a Health Service Provider (HSP) may lawfully restrain or detain a person in a non-authorised setting.

If a patient is not subject to the MHA 2014 in the specific circumstances noted above, or there are no concerns about the patient's decision-making capacity, they cannot lawfully be restrained or detained.

Patients with legal capacity have the right to decide what should or should not be done to them. This includes refusing advice or medical treatment, even when this is not considered to be in their best interests or risks their death.

Consulting a doctor or attending a hospital or health care facility does not imply consent to the treatment offered and a patient may withdraw their consent at any stage during treatment.

Before seeking to apply a restrictive practice, the following should be fulfilled:
- all reasonable and less restrictive options have been tried or considered (including de-escalation and distraction practices and processes);
- the use of a restrictive practice is absolutely necessary to prevent serious and immediate harm to the patient or another person;
- the patient's underlying medical conditions (including pregnancy), past trauma, cultural and social diversity have been considered, where this information is available; and
- the use of restrictive practices is applied in a manner that affords the patient dignity and respect.

The application of a restrictive practice should always be:
- viewed as a temporary measure and ceased when no longer authorised.
- **reasonable and proportionate** to the circumstances.
- re-assessed regularly and removed/reduced as soon as the level of risk/harm has diminished.
- documented, including the details of the situation, the reasons for the decision and actions taken, and the monitoring and observations of the patient during and after the restraint.
- subject to a reporting and review process by the HSP.

Giving a direction to a security officer to apply a restrictive practice
Generally, a clinician will need to issue the direction to apply a restrictive practice. When doing so, clinicians should ensure they provide sufficient information to confirm its application in this case is lawful.

Refusing a directive to use restrictive practices

No WA Health employee should apply a restrictive practice to a patient if they believe doing so would be unlawful. In these situations, staff should clearly explain their concerns to the relevant clinician and/or follow the relevant local HSP escalation process. If appropriate, non-restrictive practices should be used to assist with managing the situation.

Practical Notes for Staff

- **Physical safety** of the patient and staff is high priority during any restrictive practice.
- If the decision around restrictive practice is complex, uncertain or with a significant possibility of a serious outcome, have you spoken with your **supervisor** or appropriate senior (before the decision if possible, or after if not possible)?
- Has proper **documentation** been completed regarding the circumstances and reasoning for the decision around restrictive practice (whether it occurs or not)?
- If it is determined that a patient cannot be detained, if required, has appropriate and timely **follow up** been promptly arranged?
- If it is determined that a patient cannot be detained, or if a restrictive practice occurs, has the next of kin or relevant **support person** been notified in a timely way, if appropriate?