

Policy Guideline

Restraint and Seclusion in Mental Health Services Policy Guideline

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Summary

The Restraint and Seclusion in Mental Health Services Policy Guideline is designed to provide staff with information to implement the SA Health Restraint and Seclusion Reduction Policy Directive; meet relevant legislative requirements; guide the development of restraint and seclusion reduction programs; ensure that when restraint or seclusion is used the person's rights and dignity are maintained; and ensure that a review process occurs to assist in preventing further incidents of restraint and seclusion.

The Toolkit included with these guidelines includes recommendations for staff training; strategies for prevention of restraint and seclusion; post incident debriefing strategies to limit the potential trauma restraint and seclusion may cause; and prevention of further episodes of use where it has occurred.

Keywords

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Does this policy replace an existing policy? N

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Yes

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Yes

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Restraint and Seclusion in Mental Health Services Policy Guideline

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Restraint and Seclusion in Mental Health Services Policy Guideline

1. Objective

These guidelines are designed to provide staff with information to:

- implement the SA Health Restraint and Seclusion Reduction Policy,
- meet relevant legislative requirements,
- guide the development of restraint and seclusion reduction programs,
- ensure that when restraint or seclusion is used the person's rights and dignity are maintained, and
- ensure that a review process occurs to assist in preventing further incidents of restraint and seclusion.

The Toolkit included with these guidelines includes:

- recommendations for staff training,
- strategies for prevention of restraint and seclusion,
- post incident debriefing strategies to limit the potential trauma restraint and seclusion may cause, and
- prevention of further episodes of use where it has occurred.

2. Scope

These guidelines are relevant to all SA Health staff who, may be required to care for voluntary and involuntary mental health patients wherever they are located in an approved treatment centre.

3. Principles

Section 7 of the *Mental Health Act* 2009 contains a set of Guiding Principles for its administration which should inform the decision making and actions of health professionals.

Mental health services should:

- be designed to bring about the best therapeutic outcomes for people, and, as far as possible, their recovery and participation in community life;
- be provided on a voluntary basis as far as possible or otherwise in the least restrictive way and in the least restrictive environment that is consistent with their efficacy and public safety, and at places as near as practicable to where the person, or their families or other carers or supporters, reside;
- be governed by comprehensive treatment and care plans that are developed in a multi-disciplinary framework in consultation with the person (including children) and their family or other carers or supporters;
- take into account the different developmental stages of children and young persons and the needs of the aged;

- take into account the different cultural backgrounds of patients;
- in the case of patients of Aboriginal or Torres Strait Islander descent, take into account the patients' traditional beliefs and practices and, when practicable and appropriate, involve collaboration with health workers and traditional healers from their communities;
- conduct regular medical examinations of every person's mental and physical health and regular medical review of any order applying to the person;
- only use medication for therapeutic purposes or safety reasons and not as a punishment or for the convenience of others;
- only use mechanical body restraints and seclusion as a last resort for safety reasons and not as a punishment or for the convenience of others;
- provide the person (together with their family or other carers or supporters) with comprehensive information about their illnesses, any orders that apply to them, their legal rights, the treatments and other services that are to be provided or offered to them and what alternatives are available;
- provide the information in a way that ensures as far as practicable that it can be understood by those to whom it is provided.

4. Detail

Restraint and seclusion are interventions of last resort used when other options have failed to maintain safety for the person experiencing distress, staff or others. Restraint and seclusion are not therapeutic interventions.

These guidelines are based on the current best available evidence on the prevention and elimination of restraint and seclusion and the management of restraint and seclusion where it is used as a last resort. They are set in the context of early intervention measures to prevent restraint and seclusion occurring and promote the principle of least restrictive practice.

4.1 Prevention

All health services should consider prevention strategies that can be implemented within their health setting. The diversity in care and treatment settings may impact on what is relevant within each environment.

MANDATORY REQUIREMENT 1 - Restraint and Seclusion are not therapeutic interventions. All efforts are made to minimise and eliminate their use.

4.1.1 Trauma informed care

The awareness, of how past experience of trauma, can impact on clinical interactions, can help prevent the emergence of challenging behaviours.

From a neurobiological perspective, trauma survivors are sensitised to stimuli that may trigger fright, fight or flight response. In order to minimise challenging behaviours, practice needs to be aimed at preventing this fear response. People presenting to Mental Health Services endorse high rates of past trauma.

Considerations include:

- Creating a welcoming environment
- Meeting people and conferring respect
- Providing options at the outset avoiding the feeling of being trapped or confined
- Minimising unnecessary and potentially aversive stimuli
- Asking permission before touching
- Creating a culture of collaboration within the team and with the person
- Having a team approach with colleagues prepared to step in and take over when interaction with the consumer is no longer therapeutic
- Ensuring that the team has working knowledge of the person's Personal Prevention Plan (PPP), if one is in place.

MANDATORY REQUIREMENT 2 - Health service staff adopt a universal precautions approach to trauma informed care for Mental Health presentations.

4.1.2 Primary prevention strategies

Anxiety is the first stage of a change in behaviour and can easily increase to a degree of agitation and aggression which can impact on the safety of all within the environment. Consideration of the effect of the environment on a person is important and effecting change within it, wherever possible, will assist in reducing a person's anxiety.

Environmental modifications that may be considered include:

- Reducing noise levels
- Ensuring privacy
- Ensuring the area is clean
- Providing orientation to the environment
- Providing natural lighting where possible
- Providing access to alternative spaces
- Providing access to outside areas.

MANDATORY REQUIREMENT 3 – Mental Health Services work at all times in the least restrictive environment.

The World Health Organisation requirements on the prevention of the use of restraint and seclusion include access for people to a 'comfort room' or 'sensory room'. Where space does not allow this, 'sensory carts' can be used (see **Toolkit Fact Sheet 6 Sensory Modulation**).

4.1.3 Engagement with any person presenting to health services

Engaging with people and the development of a therapeutic relationship are the basic fundamentals of mental health care.

MANDATORY REQUIREMENT 4 – Services are person centred at all times.

A service that is person centred will ensure that each consumer:

- Receives an orientation to the environment and the service including the values of the service
- Knows which staff member is available and how to access them
- Has their legal rights explained in a format they can understand
- Is informed of their rights and responsibilities and the rights of others
- Is informed about how to access advocacy services
- Knows how to make complaints about the service and their treatment; and
- Is informed of what may happen if their behaviour becomes significantly disturbed or dangerous to themselves or others and be given an opportunity to determine how this should be handled.

Being polite, respectful and using empathic listening in all interactions and meeting immediate needs is an important aspect of respectful behaviour and consistent with trauma informed care and the recovery model.

On meeting the person:

- Introduce yourself
- Ask their name and what they like to be called
- Ask if they need something to eat or drink
- Ask what you can do for them today
- Understand any questions they may have.

4.1.4 Communication

Body language and non-verbal communication comprise 90% of all communication. The following considerations are important in order to demonstrate respect and empathy for the person:

- listening without interruption
- tone, volume and cadence of voice
- respecting the person's personal space
- body language - non-threatening and non-judgemental
- paraphrasing to ensure understanding

MANDATORY REQUIREMENT 5 – Communication with the person and colleagues is always respectful.

The **Personal Prevention Plan (PPP)** within the **(Toolkit Fact Sheet 4 Personal Prevention Plans)** will assist in engaging with a person and finding out what agitates and distresses them, signs and symptoms they might exhibit when agitated and calming strategies that work for them.

If a PPP has been completed, it must be accessible and all clinical staff providing care are to have working knowledge of that plan.

4.1.5 Availability of meaningful activities

All units should have a structured activities program available for people. A structured day has been proven to assist people with reducing boredom and improving interaction with others, and is an opportunity to add to the assessment of the person's mental state and progress towards recovery and discharge.

Having a choice of activities and calming strategies varies depending on the environment and the clientele within the environment, and can include both active and sedentary activities, such as:

- Music
- Meditation or spiritual reflection
- Word games
- Cards
- Walking groups
- Sports
- Culturally significant activities

MANDATORY REQUIREMENT 6 – All bedded services will provide meaningful and structured program that offers choice and can be personalised.

Further options are listed on the **PPP** and **Activities** list in the **Toolkit, Fact Sheet 1 Activity programs for Mental Health Units and Fact Sheet 4 Personal Prevention Plans**.

An individual structured activity plan should be developed for any inpatient as a routine part of the admission process, depending on their level of functioning and needs at the time (**see Toolkit Fact Sheet 1 Activity programs for Mental Health Units**). This should be introduced in the first 24 hours of admission and completed within the first 48 hours. Activities should be available over seven days and for extended hours in any inpatient setting.

In addition, a range of educational activities and group therapy opportunities should be included in the care and treatment plan developed for each person. Examples include:

- Motivational interviewing
- Solution focused therapy
- Brief interventions
- Creative therapies (art, music and writing)
- Early warning signs
- Healthy living
- Single exposure work
- Cognitive behavioural therapy
- Mindfulness
- Self-management

Peer Specialists should be included in presenting or facilitating groups and activities within the unit.

The use of assessment tools to more accurately determine a person's treatment needs

(including the use of the HoNOS, LSP and K10 and 'risk of violence' tools) can assist in predicting who may become aggressive, and implementing a plan to mitigate the identified risks.

4.2 De-Escalation

For many people who experience a period of escalating agitation whilst receiving treatment in any health service, staff can determine the cause of the agitation and implement de-escalation strategies to return the person to a calmer state.

4.2.1 Causes of agitation

Triggers may be many and varied and often, utilising supportive and empathic communication will be enough to prevent the situation from escalating further.

MANDATORY REQUIREMENT 7 – The person's assessment and care is inclusive of monitoring distress.

Some examples of triggers include:

- Fear
- Pain and/or discomfort
- Frustration
- Poor self esteem
- Lack of choices
- Not being listened to
- Sadness
- Displaced anger
- Loss of power and/or control
- Environmental
- Drug and alcohol issues
- Medical illness
- Stigma

MANDATORY REQUIREMENT 8 – Emerging distress is responded to promptly, respectfully and ethically.

4.2.2 De-escalating agitation

Observing the person's body language will often provide an understanding of what they may be feeling which may be used as an opening to acknowledge their feelings and encourage them to discuss them further.

It is important at this point to remain calm and continue communicating with the person using an empathic and respectful approach, modulating your response to the level of agitation the person is displaying.

The aim is to find the most appropriate behaviour to bring about a positive response in their behaviour. What you do will affect the person; if you display agitated behaviour, the situation may escalate.

MANDATORY REQUIREMENT 9 – (a) Team responses are trained and least restrictive (b) One member is responsible for continuous communication with the consumer.

In the first instance, if the person is beginning to vocalise or behave in a threatening manner, consider whether you need to retreat and request assistance from others to help you restore calm.

Do not hesitate to call for assistance if required. A team response can help you feel safer and subsequently ensure that your body language and voice control remain neutral and respectful. A team response does not mean a hands-on or physical intervention will occur. The reason for the team arrival should be explained to the person, "The others are here to make sure we all stay safe."

This can be threatening to the person and it is important that a single staff member assumes responsibility for communication and reassurance. This should be a component of team training and practice.

Revisit the person's PPP or Advanced Directive (see **Part 11**) is there anything they have previously determined as a calming strategy that can be utilised at this point?

If a person has become defensive they may not be thinking rationally. There is an opportunity to consider a number of options:

- Do they need more information or to have things explained in another way?
- If asking the person to do something, consider if it needs to occur now or can be done later – avoid a power struggle
- The person may not be able to make connections between their actions and the consequences and the use of limit setting may be helpful. **(See Toolkit Fact Sheet 3 Limit Setting).**
- Anger is an 'okay' emotion - allow the person to vent if possible and in private.

You are responsible for ensuring you maintain a professional response to a person's behaviour and this can be achieved by caring for yourself and each other within the work place.

Ways in which you can care for yourself and your colleagues include:

- Access to clinical supervision
- Access to Employee Assistance Schemes
- Ongoing access to education and training
- Being respectful to each other
- Having a work / life balance
- Utilising mindfulness techniques
- Access to debriefing post incidents
- Utilising reflective practice
- Access to lived experience workers
- Understanding your own fears and anxieties
- Engaging in sport / physical activities
- Practicing drills of response
- Removing yourself from the unit during meal breaks
- Developing non-violent crisis intervention techniques

MANDATORY REQUIREMENT 10 – Staff must promote healthy work practices and mutual respect.

The escalation of a situation to the point of imminent or actual aggression is not a linear process. However, in many instances the above strategies will prevent or reduce the chances of aggression occurring.

MANDATORY REQUIREMENT 11 – All least restrictive options will be

considered before restraint.

Before implementing any restraint, assess that the following options have been exhausted:

- Offer counselling, either with yourself or someone the person will feel comfortable with. Consider the use of a Traditional Healer for Aboriginal people or a Peer Specialist.
- Has the person's PPP been reviewed and discussed with the person? What are their triggers, early warning signs of agitation and calming strategies?
- Implement an agreed 'calming' strategy from their PPP or identify a strategy with the person in the moment.
- Consider diversional activities that are possible and appropriate to do within the environment.– a walk, listening to music, drawing
- Access to a 'comfort' room - a safe, comfortable environment where sensory modulation can be used is helpful for many. A reduction in anxiety can occur with either an increase in stimulation or a reduction in stimulation (**see Toolkit Fact Sheet 6 Sensory Modulation**).
- Offer medication to reduce anxiety or agitation if part of the person's PPP or if the above measures have been unsuccessful.

4.3 Restraint

The definition of restraint is the restriction of an individual's freedom of movement by physical or mechanical means. This applies to person's receiving specialist mental health care. (Mental Health Drug and Alcohol Principal Committee , Safety and Quality Partnership Standing Committee, Restraint working group, Draft National definitions for Restraint, 2014)

Restraint may be chemical, physical, mechanical, or environmental (seclusion). Seclusion is addressed in **Part 4.4** of this document. It is an intervention of last resort to control imminent or actual risk to self or others. Any use of physical force significantly increases the chance of injury occurring to staff and/or the individual involved.

MANDATORY REQUIREMENT 11 – Restraint is used as an option of last resort.

4.3.1 Reasons for restraint

Restraint may be used only as a last resort to:

- Ensure safety of the person and others only if the risks of not restraining outweigh the risk of restraining; and
- Ensure provision of medication and treatment deemed essential and required immediately; and/or
- Prevent the person from leaving when under care and control or on an Inpatient Treatment Order (ITO).

You are encouraged to discuss the potential use of restraint in extreme circumstances with the person to develop an Advanced Directive (See **Part 11**)

Other distress management techniques must continue to be employed once the initial symptoms have been alleviated and may help the person to build skills in managing further distress.

4.3.2 Application of Restraint

MANDATORY REQUIREMENT 12 – Restraint is administered safely by a team trained in application of method used.

Where a person is restrained chemically, physically or mechanically arrangements are in place for:

- continuous observation
- 15 minute minimum blood pressure, pulse, respirations and pulse oximetry
- Access to emergency resuscitation equipment.
- Any additional monitoring indicated by the agents used (eg. ECG monitoring).
- Communication is to be maintained with the person by the appointed response team. (**Part 4.2.2**)
- Access to food, fluids, personal comfort (eg. hair not falling into face) and toilet facilities
- Restraint should be ceased as soon as the person's safety can be maintained or they can assure staff that they or others are not at risk.

MANDATORY REQUIREMENT 13 – All people who are restrained or secluded of mental health consumers are observed and monitored continuously throughout the incident.

Inform family and carers as soon as practicable of the restraint incident and explain reasons for the use of restraint.

All incidents of restraint or seclusion are to be entered on the Safety Learning System and any other relevant electronic database system. (Refer to the attached **Chief Psychiatrist Standard: Seclusion and Restraint – recording and reporting**)

MANDATORY REQUIREMENT 14 – All incidents of restraint or seclusion of mental health consumers are recorded on an auditable database and reported to the Chief Psychiatrist.

4.3.3 Risks of restraint

MANDATORY REQUIREMENT 15 – The physical health of the person is considered in the course of restrictive interventions including restraint and seclusion.

There can be significant risks associated with restraint, including:

- Emotional trauma
- Re-traumatisation
- Death

Further, each category of restraint brings its own set of unique risks:

Restraint Type	Risks
Chemical	<ul style="list-style-type: none">• Memory issues• Respiratory depression
Physical	<ul style="list-style-type: none">• Positional asphyxia• Rhabdomyolysis• Strains and sprains• Acidosis

Mechanical	<ul style="list-style-type: none"> • Bruising • Neuropathy • Positional asphyxia
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4.3.4 Chemical Restraint

The *Mental Health Act 2009* states that medication should not be used as a punishment or for the convenience of others, but only used for therapeutic purposes or safety reasons.

MANDATORY REQUIREMENT 16 – Medication used must be consistent with PPP or standard sedation protocols for the service.

Medication, while not an alternative to prevention and de-escalation strategies, may be used to manage acute mental illness that may underlie challenging behaviour in addition to these strategies or where these measures have been unsuccessful.

MANDATORY REQUIREMENT 17 – Sedation protocols must be in place for the treatment centre and based on current evidence and best practice.

The most commonly used agents are benzodiazepines and antipsychotics. Where medication is used to manage challenging behaviour, the principal aim must be to allow further psychological and medical evaluation and management of the person and must be guided by:

- Pharmacological agents identified in the PPP as having proven efficacy in helping the person manage heightened states of fear and distress
- Pharmacological management of challenging behaviour protocol (also called “sedation protocol”) that sets out recommendations for clinicians of a given centre or agency based on safety, least restrictive (monotherapy, lowest dose) and least intrusive approaches (route of administration) and consideration of the person’s circumstances (age, physical health status, comorbidities).

The Glasgow Coma Scale (GCS) can be used to monitor the level of sedation of the person.

The use of chemical restraint for mental health consumers resulting in a GCS below 11 requires notification to the Office of the Chief Psychiatrist and Mental Health Legislation and Policy within 24 hours or as soon as practicable.

4.3.5 Physical Restraint

Physical Restraint is defined as 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 to ensure the provision of essential medical treatment. (Mental Health Drug and Alcohol Principal Committee, Safety and Quality Partnership Standing Committee, Restraint working group, Draft National definitions for Restraint, 2014)

Physical restraint can only be undertaken by an appropriately trained team. The training must include the utilisation of non-harmful techniques and avoidance of prone restraint where ever possible. Prone restraint is not to be used on a bed or barouche and must never continue for longer than three minutes.

A response team should consist of five to seven people, although not all are expected to provide hands on restraint; this would be done by 3 to 5 people as required. Evidence has demonstrated that more than 5 people may result in greater chance of injury. The restraint should not commence until a full response team is present.

Teams should be provided with an opportunity to practice drills and have training in a variety of settings or scenarios to improve their responses. De-escalation techniques should continue to be used during physical restraint and the restraint should be removed as soon as practicable.

If, during a physical restraint, the person ends up in a prone position on the floor:

- Allow them to bring their forearms up under the chest to promote chest expansion and safe, effective respirations. This significantly reduces the risk of positional asphyxia.
- Let go if it is considered safer to do so, then re-apply restraint as required
- Assist the person up from the floor while maintaining the physical restraint
- Consider other measures to manage challenging behaviour if verbal de-escalation is unsuccessful.
- The person should be assisted from the floor within three minutes.

MANDATORY REQUIREMENT 18 – Prone restraint should be avoided and must cease within 3 minutes.

A person who suddenly stops resisting a physical restraint may be experiencing cardio-respiratory de-compensation. This constitutes a medical emergency.

4.3.6 Mechanical Restraint

Mechanical restraint is defined as 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 to 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. (Mental Health Drug and Alcohol Principal Committee, Safety and Quality Partnership Standing Committee, Restraint working group, Draft National definitions for Restraint, 2014)

To place a person in mechanical restraints, the use of physical restraint is required and the practices in **Part 4.3.5** should be followed to enable the mechanical restraints to be applied safely and appropriately. Consideration should be given to determining the most appropriate type of mechanical restraint to use in individual situations.

Hard shackles or canvas clothing are not considered appropriate items to use for restraint purposes. Their use in exceptional circumstances must be guided by a multidisciplinary care plan and thorough evaluation of risk.

Services must:

- Only use mechanical restraint devices approved by the Chief Psychiatrist for the management of challenging behaviour.
- Maintain a list of devices approved for use within the facility.
- This list must be available for inspection.

- Notify the Office of the Chief Psychiatrist and Mental Health Policy of any new devices introduced.
- Provide training to relevant staff on the use and application of each device being used.
- Consider the need, appropriateness and any safety issues associated with new practice / methods of restraint.

The use of mechanical restraints requires a Medical Officer authorisation. However, in an emergency, a Registered Nurse may authorise the use and review by a Medical Officer should occur within one hour.

During restraint the person must be in a supine position with the head of the bed raised to promote adequate respiration. If the person is moving significantly and a risk of tipping the barouche / bed is present:

- Lower the barouche / bed to reduce the centre of gravity
- Where possible, have one side against a wall
- Raise the head of the barouche / bed to reduce forward momentum

Consider using an oxygen mask with 2L of O₂ if the person is spitting.

Mechanical restraint should be removed as soon as possible to avoid muscle breakdown and maintain skin integrity. If restraint is prolonged:

- Release each limb, one at a time if necessary, for 10 minutes each hour
- Release the device and allow the person to stand / roll / walk at least every four hours.

4.4 Seclusion

4.4.1 Introduction

Defined as the confinement of a person, alone in a room or area from which free exit is prevented. (*National Documentation, MHSRP, 2009*)

The following situations are also to be treated as seclusion:

- Where a person is placed in a room and they believe the door is locked
- Where a person is kept in an 'area' by themselves for example via the use of a security guard.

Removing or reducing stimulation may increase agitation and distress in some people through sensory deprivation, isolation and exacerbation of their sense of loss of control.

A trained response team should be used to place a person in seclusion and be available for reviews of the person during the seclusion episode.

Seclusion rooms/areas should have:

- Natural light available if possible, so the person can more readily orientate themselves. Lighting should be determined by the individual's request.
- A clock viewable by the person.
- Access to toilet facilities.

The person is to be offered food and fluid which can be at regular meal times, however flexibility will be required.

High risk times for injury during seclusion are during times of entering and exiting the seclusion room.

- On entering seclusion, the person is placed face down on a covered mattress (this is the only time where prone restraint may be purposely initiated). This is to occur for a maximum of three minutes and is to allow administration of any indicated intramuscular medication and safe exit for staff.
- The person should be immediately allowed to bring their forearms up under their chest as described in **Part 4.3.5**.
- When staff are exiting the seclusion room following a restraint, wrapping a blanket around the person's legs to temporarily limit their movement will reduce the incidence of harm when closing the seclusion room door.

4.4.2 Observations while Secluded

- Visual observation while in seclusion is to be continuous and occur face to face
- Observation may be at a point adjacent to the seclusion room / area.
- Consideration of alternative strategies discussed at each review point.
- Consideration of ceasing seclusion if safe to do so at each review point. Refer to the Chief Psychiatrist Restraint and Seclusion Standard – applications and Observation Requirements.

In conjunction with:

- 15 minute observation of behaviour
- 15 minute verbal contact with the person to assess ongoing need for seclusion
- Medical review after 1 hour.
- Further medical review at four hours if unable to cease seclusion prior to this
- Inform Consultant Psychiatrist at four hours if assessment indicates ongoing seclusion
- Consultant Psychiatrist review at eight hours
- Each observation point should include a comment on behaviour and conversation, and if food, fluid, medication or toileting were offered and/or received.

If a person has been lying / sitting quietly within the seclusion room / area for 30 minutes or more, imminent cessation of the seclusion should be considered and reasons for not doing so documented on the seclusion record.

Make note of the position of the person - if a person has not moved when lying in seclusion for two hours, immediate review should be implemented as this may indicate a significant and potentially dangerous level of sedation has occurred if medication has been used.

4.5 Debriefing following an incident of restraint or seclusion

The use of restrictive interventions such as restraint and seclusion has the potential to cause trauma and/or re-traumatise some individuals, and all efforts should be made to mitigate this risk. Effective intervention following a seclusion or restraint also has the potential of assisting with determining prevention strategies for the future.

MANDATORY REQUIREMENT 19 – All people who have been restrained or secluded receive post incident debriefing.

After a seclusion or restraint episode:

- Offer the person a drink, an opportunity to go to the toilet or some space to themselves for a while. It can take 60 to 90 minutes for the adrenaline release that occurs during a distressing incident to dissipate and for the person to regain physical control of themselves.
- The person, their family and/or carers, staff and any other people in the area should be given an opportunity to discuss what occurred. A pro forma for debriefing is available in the **(see Toolkit Fact Sheet 7 Debriefing following an incident of restraint or seclusion)**.
- and this can be used for the person who has experienced seclusion or restraint, visitors, family, carers or other people in the area.

MANDATORY REQUIREMENT 20 – The person’s family and support person/s are supported following an incident of restraint or seclusion.

MANDATORY REQUIREMENT 21 – Staff are provided with support and debriefing following an incident of restraint or seclusion.

Ascertaining the perspective of all who witnessed the incident will assist with reducing trauma to those involved. This allows them to tell their version of events and assist in determining future prevention strategies.

Involvement of a Peer Specialists and Carer Consultant in the debriefing process with the person who was restrained or secluded is mandatory.

The post incident debrief will help:

- Determine if there are any patterns to the person’s behaviour and to the staff response.
- Investigate alternative strategies to avoid another incident for the person, including alternative staff responses, and
- Negotiate a new plan for the person and for the staff response to try to prevent further incidents.

Longer term follow-up of the person who has experienced the restraint or seclusion should be highlighted in the discharge/transfer of care summary along with consideration given to a more structured counselling process where indicated.

Staff may benefit from the Employee Assistance Program and should be reminded of its availability.

At a team or service level, a review of the case notes and care plan and discussion about systemic processes should be undertaken at a restraint and seclusion review committee.

4.6 Cultural Specific Considerations

There is diversity across communities, languages and cultural practices of people who present to SA Health services. Staff should be provided with appropriate cultural training to care for and communicate effectively and respectfully in order to deliver the best service possible.

4.6.1 Aboriginal and Torres Strait Islander People

While 1.7% of South Australians identify as being Aboriginal, they represent over 5% of

people admitted to mental health inpatient services and more than 14% of people admitted to a psychiatric intensive care unit, 10% of people on a Community Treatment Order and 5.5% of people on an Inpatient Treatment Order.

This puts Aboriginal people at greater risk of restraint and seclusion than what would be expected from their proportion of the general population and the use of culturally appropriate, prevention and calming strategies should be utilised.

Further training on trauma informed care is also of particular importance when caring for Aboriginal people. It is expected that staff will attempt to determine what is appropriate for each individual person with due consideration of their individual beliefs and practices.

An awareness of the trauma experienced by Aboriginal people is important. Aboriginal people have been subjected to varying degrees of trauma, violence and marginalisation within the community and the risk of re-traumatising this group is significant.

When compared to the general population Aboriginal women and men have 70% greater risk of being subject to domestic violence and are at greater risk of incarceration and subsequent trauma associated with this. Mistrust of institutional structures and staff working within may be present in these circumstances.

Care and consideration should be given to the relationship Aboriginal people have to the land and that cultural issues can vary considerably between Aboriginal communities.

Care and consideration is also required in relation to the age and sexuality of the Aboriginal person.

Behaviours that may have some cultural basis include:

- Needing to 'yarn' and/or tell 'stories'
- Shyness
- Limited eye contact
- A need to feel the earth
- A need to be outside
- Hiding the face when smiling
- Not interacting with the opposite sex
- Cultural constraints on interactions and activities due to having undertaken traditional lore
- Hearing ancestors talking
- 'Sorry cuts' for the acknowledgement of grief or sorrow

When an Aboriginal person is admitted to a mental health facility, the use of a Traditional Healer should be considered and access to one provided upon request. Further, a prompt determination regarding the need for an interpreter and/or cultural advisor must be made and facilitated as soon as practicable. Involvement of an Aboriginal Liaison Officer can facilitate these processes.

Further information on health services for Aboriginal people is available at:

<http://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Health+services/Aboriginal+health+services/>

4.6.2 Culturally and Linguistically Diverse People (CALD)

People from CALD communities also require specific considerations to avoid the use of restraint, seclusion and traumatisation. The first step is to consider if an interpreter and/or cultural advisor is required to ensure effective communication.

CALD status is determined on country of birth information, which shows that 8.6% of the South Australian population were born in countries where English is not the primary language. Statistics from databases across SA Health indicate that people of CALD status make up 19% of people in older extended care settings and 30% of people in aged care settings. Approximately 45% of people admitted to an older persons' mental health unit will experience restraint.

There are increasing numbers of people from CALD communities who have come from war torn countries, have been the victims of abuse and torture in their country of origin, or have been subjected to lengthy periods of incarceration upon arrival in Australia. The risk of re-traumatisation is significant among this group. Their fear of authority figures may be substantial and care with the use of security staff is advised.

Cultural issues, such as access to a place and time for prayer, may be enough to reduce significant stress for people in this group. Providing appropriate options for food (such as halal food) and, where ever possible, utilising the same gender of staff to the individual are other considerations.

Religious holidays or periods of cultural or religious significance should also be acknowledged, for example Ramadan (Islamic), Yom Kippur (Judaism) and Navratri (Hindu), while not assuming a person follows a particular religion because of their country of origin.

Staff should be provided with access to cultural training, and where possible, ensure it relates to the demographics of their work region if there are significant numbers of specific cultural groups within that region. Again, trauma informed care is pertinent training to caring for many people within the CALD community in a respectful and holistic manner.

Where linguistic barriers exist, qualified interpreters should be used as early as possible to explain what is happening to both the consumer and their carers or family. This is important to avoid confusion or mistrust. The use of diagrams, telephone based interpreting, online translation for those who can read, assist to keep the person calmer when face to face interpreter services are difficult to access.

It is crucial, where linguistic barriers exist, that extra attention is given to body language and non-verbal communication. Whilst your words may not be understood, you can reduce the consumer's anxiety by being caring and polite.

For example:

- Monitor your tone, volume and cadence of the voice. It is often easy to inadvertently raise your voice if you are not being understood, however, please keep in mind that if the person does not have hearing difficulty, this will be seen as being aggressive.
- Is your body language non-threatening and non-judgemental?
- Are you respecting the person's personal space?

Some useful contacts for improving services for CALD people or accessing staff training include:

- **Survivors of Torture & Trauma Assistance & Rehabilitation Service**
Ph: (08) 8206 8900
- **Migrant Resource Centre SA**
Ph: (08) 8217 9500

- **Multicultural communities Council of SA**
Ph: (08) 8345 5266
- **Translator and Interpreter Service (TIS National)**
Ph: 13 14 50
- **SA Refugee Health Network at:**
http://www.sarhn.org.au/SARHA_Links
- **Multicultural Services at:**
<http://www.sa.gov.au/subject/seniors/help+for+older+people+from+a+non-english+speaking+background/multicultural+services>

4.7 Age Specific Considerations

The impact of an individual's cognitive and psychological maturity and any problems with communication and behaviour requires consideration by staff. Personal Prevention Plans (PPPs) and activity programs should be tailored to age appropriateness, strategies and language, and the use of weighted blankets as a calming strategy should be adjusted to the person's weight to prevent injury.

Restraint techniques should be tailored to the individual and not standardised across all age groups.

4.7.1 Children and Adolescents

Developmental considerations are essential in the management of challenging behaviour in children and adolescents. Since children and adolescents may not have developed adequate verbal skills to express how they are feeling, behaviour should be viewed as a form of communication and you should ask yourself "what feeling is this behaviour trying to express?" Responses can then be tailored to the young person's level of development.

The type of restraint used for children and adolescents is to be considered in the context of their height and weight, which are often much less than that of an adult. At no time should a child be held in a prone position.

4.7.2 Older Persons

Services for older people have a greater percentage of individuals from a non-English speaking background than other mental health services, making up 30% of the people in older persons services compared with 9.8% in adult acute settings. This requires staff to consider service provision that is responsive to the cultural needs of this group and if interpreter services are required. (Refer to **Part 4.6.2**)

The involvement of the person's family in determining social, cultural and activity needs to populate a PPP will assist in providing individualised care to this group.

The use of mechanical restraint within older person services is much greater than in other parts of the health service and staff are expected to use the least restrictive device, for the shortest possible time, and to be trained to apply the device correctly and safely.

Prevention of falls (often reported as prevention of harm to self) is the most common reason given for utilising restraint among this group. However, muscle deterioration begins at four hours when there have been significant physical restrictions in place, which

suggests that utilising restraints in the elderly can actually increase the risk of falls in the medium to longer term. All mechanical restraints must be released at least four hourly and the person given an opportunity to ambulate (with assistance if required) and/or be provided with passive limb exercises.

The importance of varying communication strategies to incorporate behavioural approaches that may be necessary if the person is affected by age related illnesses such as stroke and dementia should also be incorporated in to the care plan.

4.8 Education

Staff in mental health services report that verbal abuse is a common occurrence within their work role and data on restraint and seclusion currently indicates an average of 200 incidents per month. The majority of staff, report only occasionally receiving education and training in de-escalation or response to aggressive behaviour.

4.8.1 Principles of Education and Training

The National Reduction of Seclusion and Restraint project recognised the need for staff education and training, and developed principles to be included in education programs:

- Provision of staff access to, and attendance at, initial prevention and de-escalation training within two months of commencing work within mental health services, and annually thereafter
- Training is inclusive of the person with a lived experience of mental illness and family and supports
- Education on the experience of verbal abuse, coercion, restraint and seclusion from different points of view (staff, family, person with lived experience) is provided
- How the training can add to the therapeutic environment and relationship between staff and people with a lived experience
- A clear guide to ensure that staff know when an intervention is safe to implement and, in particular, when to call for assistance. This may include a risk assessment for the potential for aggression and violence, but should focus on the appropriate verbal intervention for people experiencing agitation and anxiety that has not reached the point of acting out
- Understanding the theory of, and antecedents to, aggressive or challenging behaviours to improve prevention strategies and the use of least restrictive practices
- Include language and cultural considerations for Aboriginal people and people from CALD communities.
- Emergency responses appropriate to the work setting.
- Post incident debriefing including lived experience workers.

All staff should be provided with training that focuses on the prevention and de-escalation of aggression and violence, as well as break away training relevant to their work environment, within two months of commencing employment and then on an annual basis as a minimum.

Training should:

- Promote prevention, de-escalation and verbal interventions and be consistent with recovery principles and practice
- Be individualised for aged care settings and children's services to ensure different communication needs are met within the training requirements
- Be designed to build on skills over time

4.8.2 Break Away Training

Break away training is aimed at training staff to escape from a consumer's hold in an emergency situation and should:

- be based on principles and consistency across techniques to promote ease of implementation and not a different move for every type of grab or strike
- not require strength to implement
- not cause harm to the person you are breaking away from
- be part of prevention and de-escalation training, but not be the main focus of the training.

4.8.3 Restraint Training

Training in the application of physical and mechanical restraint should:

- be limited to those who are on response teams
- have a strong ethos of avoiding restraint even when a team response is requested
- be focused on keeping the restraint to the least restrictive possible, for the minimum amount of time required to re-establish safety
- avoid prone restraint wherever possible and limit it to three minutes when it does occur
- be appropriately adapted to the client group (children, older persons, persons with a physical impairment or other health condition)
- include consideration of any prior preference expressed by the individual concerned
- include developing practice and scenario training for teams.
- only be for approved devices and techniques.

5. Roles and Responsibilities

Eliminating the use of restrictive practice must be supported by clear leadership commitment.

Executives

The Chief Executive of the Department for Health and Ageing:

- Sets overall policy on public health matters.
- Reports to the Minister on the progress of the SA Health Mental Health Reforms.

Deputy Chief Executive and Executive Director Health System Performance:

- Ensures a consistent approach and monitors the implementation of the *Restraint and Seclusion in Mental Health Services Policy Guideline* in South Australian facilities in collaboration with Local Health Networks.
- Monitors the performance of services and evaluates the initiatives impact from a statewide level.

Chief Psychiatrist:

- Develops, monitors and reviews the *Restraint and Seclusion in Mental Health Services Policy Guideline* and associated standards.

Chief Executive Officers of the Local Health Networks:

- Ensure a consistent approach and monitor the implementation of the *Restraint and Seclusion in Mental Health Services Policy Guideline*, in South Australian facilities in collaboration with Local Health Networks.
- Ensure services have implementation systems to support *Restraint and Seclusion in Mental Health Services Policy Guideline* associated Policy Directives.
- Ensure health services and facilities are resourced to support this Guideline and the associated Chief Psychiatrist Standards.

Clinical Directors

The Clinical Directors of Local Health Networks, Area Mental Health Services and Emergency Departments.

- Provide strategic leadership, workforce and organisational development to ensure local health systems use least restrictive practice and reduce the use of seclusion and restraint.

Managers and Clinicians

- Ensure clinical staff are provided with continuing education and support in least restrictive practice and the use of seclusion and restraint.
- Ensure reduction in the use of restraint and seclusion and engage in monitoring of quality care and patient and population health outcomes to inform quality improvement.

6. Reporting

- Refer to the Chief Psychiatrist Standard - Restraint and Seclusion – Recording and Reporting

7. EPAS Considerations

- Restraint and Seclusion is recorded as part of the electronic record which is built in to EPAS.
- Any incidents of Restraint or Seclusion are also entered in to the Safety Learning System as a matter of process.

8. Associated Policy Directives / Policy Guidelines (if applicable)

- Office of the Chief Psychiatrist and Mental Health Policy Seclusion and Restraint Standard – Recording and Reporting
- Office of the Chief Psychiatrist and Mental Health Policy Seclusion and Restraint Standard – Application and Observation Requirements
- National Practice Standards for Mental Health Workforce, 2002, Commonwealth of Australia

- National Standards for Mental health Services, 2010, Commonwealth of Australia

9. References, Resources and Related Documents

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fear, to the practice of compassion, Canterbury Action on Mental Health and Addictions, 2012

Mental Health Statement of Rights and Responsibilities, 2009, Commonwealth of Australia

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Peninsular Health, Personal Safety Plan, 2010, Victoria

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South Australia's Mental Health and Wellbeing Policy, 2010 – 2015, Government of South Australia

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Te Pou o Te Whakaaro Nui, Environmental factors and outcomes in mental health and addiction clinical settings: Brief summary of the literature, 2012

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Legislation

South Australian Legislation:

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Criminal Law Consolidation (Self Defence) Amendment Act 1997

Criminal Law Consolidation Act 1935

Fair Work Act 1994

Occupational Health Safety and Welfare Act 1986

Public Sector Management (PSM) Act 1995

SA Racial Vilification Act 1996

South Australian Equal Opportunity Act 1984

The Mental Health Act 2009

Work Health and Safety Act, 2012

Training and Skills Development Act 2003

Workers Compensation and Rehabilitation Act 1986

Australian Government Legislation:

- Age Discrimination Act 2004
- Disability Discrimination Act 1992
- Human Rights and Equal Opportunity Commission Act 1986
- Racial Discrimination Act 1975
- Sex Discrimination Act 1984
- Trade Practices Act 1974
- Optional Protocol Convention Against Torture, OPCAT, 2007

10. National Safety and Quality Health Service Standards (if applicable)

The Australian Commission on Safety and Quality in Health Care has developed [10 National Safety and Quality Health Service Standards](#) (the Standards).

The Standards provide a nationally consistent and uniform set of measures of safety and quality for application across a wide variety of health care services. They propose evidence-based improvement strategies to deal with gaps between current and best practice outcomes that affect a large number of patients.

National Standard 1 Governance for Safety and Quality in Health Care	National Standard 2 Partnering with Consumers	National Standard 3 Preventing & Controlling Healthcare associated infections	National Standard 4 Medication Safety	National Standard 5 Patient Identification & Procedure Matching	National Standard 6 Clinical Handover	National Standard 7 Blood and Blood Products	National Standard 8 Preventing & Managing Pressure Injuries	National Standard 9 Recognising & Responding to Clinical Deterioration	National Standard 10 Preventing Falls & Harm from Falls
✓	✓		✓	✓	✓			✓	✓

11. Other

Advanced Directive

Advance directive is the overarching term used to describe legal documents that enable competent adults to:

- appoint one or more substitute decision-makers to make decisions on the person’s behalf and/or
- write directions, wishes and values (provisions) regarding future health care, accommodation, residential or personal matters.

To complete an advance care directive a person must be *competent* (understand the nature and effect of completing the document) and be doing so free from coercion or undue influence. Adults are presumed in law to be competent unless there was evidence to the contrary at the time the advance care directive was completed.

Existing formal documents (Advanced Directives) will become Advanced Care Directives

after 1 July 2014 with the operation of the *Advanced Care Directives Act 2012*.

Medical Agents and Enduring Guardians will become substitute decision makers. Informal agreements such as Ulysses agreements will need to be changed to Advanced Care Directives by all parties working together.

12. Evaluation

Key Performance Indicators

- 1. Rate per 1000 bed days of seclusion and restraint**
 - a. Numerator - Number of incidents of restraint and seclusion
 - b. Denominator – total number of bed days x 1000

- 2. The rate of restraint or seclusion lasting more than 4 hours in one incident**
 - a. Numerator – Number of incidents of restraint or seclusion lasting more than four hours
 - b. Denominator – number of incidents of restraint or seclusion

- 3. The rate of restraint or seclusion where review by an MO within the first hour did not occur**
 - a. Numerator – number of restraint or seclusion incidents not reviewed within an hour by an MO
 - b. Denominator – number of incidents of restraint and seclusion

- 4. Rate of people who are restrained or secluded more than once**
 - a. Numerator - Number of people restrained or secluded more than once in a care episode
 - b. Denominator – number of people restrained or secluded

- 5. Rate of complications from a restraint or seclusion incident**
 - a. Numerator – number of incidents where complications occur
 - b. Denominator – number of incidents of restraint or seclusion

6. Attachments

Attachment 1 - Restraint and Seclusion Policy Guidelines Toolkit

- Fact sheet 1 Restraint and Seclusion - Activity Programs for Mental Health Units
- Fact sheet 2 Restraint and Seclusion - Agitation Scales
- Fact sheet 3 Restraint and Seclusion - Effective Limit Setting
- Fact sheet 4 Restraint and Seclusion - Personal Prevention Plan
- Fact sheet 5 Restraint and Seclusion - Guide to Review of Restraint and Seclusion and Audit tools
- Fact sheet 6 Restraint and Seclusion - Sensory Modulation
- Fact sheet 7 Restraint and Seclusion - Debriefing following an incident of restraint or seclusion
- Fact sheet 8 Restraint and Seclusion reporting

Attachment 2 – Chief Psychiatrist Standard: Restraint and Seclusion - Application and Observation Requirements

Attachment 3 - Chief Psychiatrist Standard: Restraint and seclusion – Recording and Reporting

7. Definitions

In the context of this document:

Acute care - specialist psychiatric care for people who present with acute episodes of mental illness.

Carer - a person who provides ongoing care or assistance to a person with a mental illness, usually a family member, and includes young carers. This does not include a person who provides care or assistance pursuant to a contract for services.

Chemical restraint – no agreed definition available.

Community mental health services - services and teams that provide mental health care services in the community, outside of hospital settings.

Consumer - a person who uses or has used mental health care or related services.

Culturally appropriate - services are culturally appropriate if they respect and take into account the cultural background, spiritual beliefs and values of a consumer and incorporate this into the way healthcare is delivered to that person.

Forensic mental health services - mental health services that provide assessment, treatment and care of people with a mental illness who are in the criminal justice system or who have been found not guilty of an offence or unfit to stand trial because of mental impairment.

Guardianship Board (GSB) - is a South Australian tribunal that has legal authority to make important decisions affecting the lives and property of people in particular specified circumstances.

Intermediate care - services that provide a high-level of care to those experiencing a serious episode of mental illness, but at a lower level of intensity than acute care services.

Least restrictive - the concept of allowing the consumer to be cared for in an environment which places the least amount of restriction on freedom of movement while maintaining their safety and the safety of others.

Lived experience – a person who has experienced mental illness and or received mental health care.

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 to 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.

NSMHS - National Standards for Mental Health Services, 2010. A description of the standards of service expected to be delivered by mental health services across Australia.

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 to ensure the provision of essential medical treatment.

Recovery - the concept of recovery describes a person's own unique and personal journey to create a fulfilling, hopeful and contributing life and achieve his or her own aspirations, despite the difficulties or limitations that can result from the experience of mental illness. It does not necessarily mean the elimination of symptoms or a return to a person's pre-illness state.

Restraint - The restriction of an individual's freedom of movement by physical or mechanical means. This applies to person's receiving specialist mental health care.

Rhabdomyolysis - is the breakdown of muscle fibres that leads to the release of muscle fibre contents (myoglobin) into the bloodstream. Myoglobin is harmful to the kidney and can cause kidney damage. Rhabdomyolysis is caused by muscles being damaged, for example by crush injuries, drugs, seizures, severe exertion and trauma.

Seclusion - Defined as the confinement of a person, alone in a room or area from which free exit is prevented. (*National Documentation, MHSRP, 2009*)

Traditional Healer - an Aboriginal healer, sometimes referred to as a Ngangkari in local SA language.