Austin Health

Clinical Ethics & Decision Making Support

CLINICAL ETHICS AND DECISION SUPPORT
CEADS

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RESTRICTIVE INTERVENTIONS - ETHICAL CHALLENGES WITH RESTRAINTS

Can restraint be part of ethical practice?

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Recent legislative changes relating to restraint in clinical practice have increased clinicians' awareness of the ethical issues in this area. The Mental Health and Wellbeing Act (2022) (the Act), which came into effect in September 2023, introduced new requirements to better monitor use of chemical restraint as a type of restrictive intervention. The new requirements are aimed at reducing the instances of restrictive interventions. These changes are not intended to restrict clinicians from using pharmacological agents for the benefit of patients, including alleviating symptoms of a person's mental illness or preventing harm to a person with acute behavioural disturbance with unknown cause.

The new requirements apply to the use of pharmacological agents for the primary purpose of controlling the person's behaviour by restricting their freedom of movement. These requirements include:

- principles to guide decision-making when considering the use of all restrictive interventions.
- an obligation to consider the likely impact of the intervention on the person, considering factors such as past trauma.
- a requirement to review the use of restrictive interventions, with an obligation to provide the person subject to the intervention an opportunity to participate in the review.
- increased obligations to document the use of restrictive interventions.

For some clinicians, the legislative changes formalise their current practice and simply introduce new documentation requirements. However, the new Act has prompted reflection and a broader conversation about past and current practices, and led some to reflect on how pharmacological interventions may be used as restrictive practices in their work.

If the primary aim is to minimise the patient's movement to protect the patient or others, including staff, the practice is considered restraint. This contrasts with a primary intention of symptom management or preventing serious harm including death, where a drug is administered for the patient's own benefit. Notably, a drug could be administered with the primary intention of symptom management and have a secondary effect of preventing harm to others. This would be considered a treatment, not chemical restraint, and is always legally and ethically justified.

While on its face the legislation is clear, determining when an intervention is chemical restraint in clinical practice can be challenging. For instance, consider a patient in the ED demonstrating agitation and escalating behaviours. We do not yet have the medical history required to understand the behaviours. There could be delirium, substance use, or mental illness at play. An antipsychotic may be considered in this situation both to facilitate assessment and to treat a patient's symptoms. The reality of clinical practice is that drugs can be administered for a variety of reasons, and it may be difficult to categorically distinguish primary and secondary purposes. Two people may look at this situation and have different views about whether administration of the drug constitutes a chemical restraint (i.e. whether its primary purpose is treatment or controlling the patient's behaviour). They may also have different views about the appropriateness of its use in the situation. The important thing to remember is to reflect upon the purpose of the administration and document your intent and clinical rationale for it.

Identifying when an intervention is a chemical restraint or when it is treatment can be a difficult task. Given the legal and ethical importance of this distinction, it is worth reflecting on individually and with colleagues. If you are unsure about whether the administration of a drug would constitute the administration of a chemical restraint don't be reluctant to administer it if you have determined that there is no less restrictive option available in the circumstances and it is necessary to prevent serious and imminent harm to the patient or another person.

The Austin Health Chemical Restraint Policy also provides helpful guidance on this question.

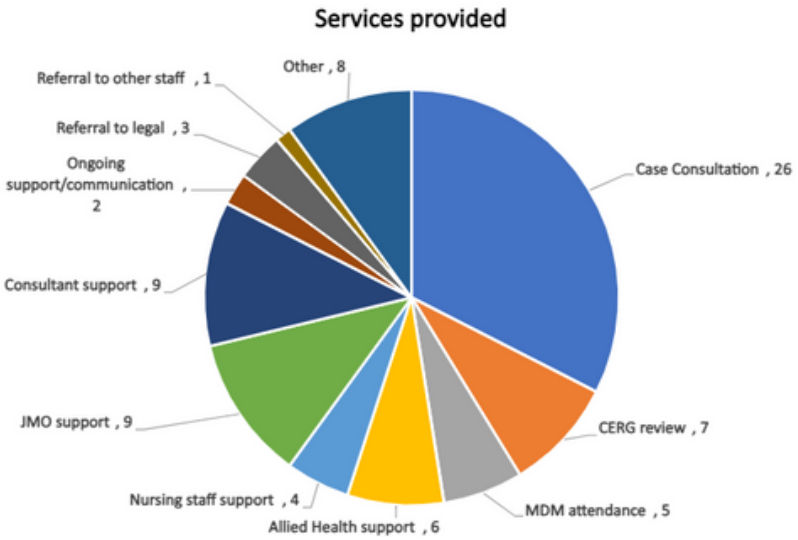
IN THE NEWS & LITERATURE

"For your own good"? Is it ethical to use chemical restraints on patients who lack capacity but wish to leave the hospital against medical advice?
Authors argue that there is a moral and ethical difference between 'being conscious' and 'being in a particular conscious state', and thus specifies conditions for the ethical application of chemical restraint.

When patients behave badly: consent, breach of the duty of care and the law
Through the lens of a hypothetical case of aggressive behaviour in the ED, this paper sketches out the legal rights and considerations regarding treatment and use of restraint in the ED.

CEADS 2023 REFERRAL SUMMARY

In 2023, CEADS received case consultation referrals from a wider range of specialties compared to previous years, with an increasing percentage of referrals from junior medical, allied health and nursing staff. Case consultations addressed diverse challenges, often with multiple intersecting ethical issues. Issues around harm and best interests, particularly for vulnerable patients, were common. Staff members' moral distress was often a catalyst for case consultation referrals. The 58 case consultations conducted in the last year came from a broad range of specialities including general medicine, allied health, psychiatry, anaesthetics and cardiology departments and influenced our Unit's organisational ethics activities through identification of recurrent themes.



2024 CALENDAR

Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
	12th CEC meeting 21st Ethics forum		24th 1400-1445 Ethics forum	CEADS Newsletter 13th CEC meeting ICCEC Conference May 29-31		17th 1400- 1445 Ethics Forum CEADS Newsletter	12th CEC meeting 28th Grand Rounds	CEADS Newsletter	2nd 1400-1445 Ethics forum	11th CEC meeting	CEADS Newsletter