Least restrictive principle

1. What do **the Act** and relevant guidance say?

Mental health and wellbeing services are to be provided to a person living with mental illness or psychological distress with the least possible restriction of their rights, dignity and autonomy with the aim of promoting their recovery and full participation in community life. The views and preferences of the person should be key determinants of the nature of this recovery and participation (s 18).

There is no hierarchy of what is considered more or less restrictive. **Least restrictive means 'the option most consistent with the person's preferences, rather than the one with less time experiencing other restrictions'**[8]**.** For example, inpatient treatment is not inherently more restrictive than community-based treatment. Understanding what 'least restrictive' looks like in practice is explored further in section 5 of this principle.

The decision making principles will generally be relevant in thinking about what is least restrictive. For example, the decision making principles state that compulsory assessment and treatment and restrictive interventions are inherently restrictive, as they significantly limit people's human rights and may cause harm including serious distress to the person, and disruption to their relationships, living arrangements, education and employment (s 80). Accordingly, compulsory assessment and treatment, or restrictive interventions, are not to be used if they will cause more harm than they are supposed to prevent (IMHA 2025).

Relevant guidance or standards that support compliance with this principle include:

- Australian Commission on Safety and Quality in Healthcare (2021) *National Safety and Quality Health Service Standards*, particularly actions 5.35 and 5.36
- Department of Health (2013) *Providing a safe environment for all: framework for reducing restrictive interventions*
- Department of Health (2024a) *Restrictive interventions: Chief Psychiatrist's guideline*
- Department of Health and Human Services (2016) *Safewards handbook: training and implementation resource for Safewards in Victoria*, and associated resources
- Safer Care Victoria's work to implement Royal Commission recommendations relating to reducing compulsory treatment and eliminating restrictive practices (see website)

8 *UVX v Mental Health Tribunal (Human Rights)* [2024] VCAT 102, 63

2. How do **human rights** relate to this principle?

Key human rights in the Charter to consider when the least restrictive principle applies include the right to equality (section 8), the right to humane treatment when deprived of liberty (section 22), the right to privacy (section 13(a)) and, among others, the right to liberty (section 21).

Related mental health and wellbeing principles include:	Related decision making principles include:
Dignity and autonomy Dignity of risk Family and carers Supported decision making Cultural safety Gender safety Lived experience Wellbeing of young people	All decision making principles are relevant to considering what is least restrictive.

3. How might a **consumer** experience this principle?

When the least restrictive principle is applied in practice:

- My rights, dignity and autonomy are always respected, and restrictions are only used when absolutely necessary and as a last resort.
- My preferences about what is helpful and least restrictive for me - whether noted directly or in my advance statement of preferences, are taken seriously and given priority.
- If restrictions are used, I am told why in a way I can understand, and what steps I can take to remove or avoid them in the future.
- If I am in hospital, I have access to tools and supports that help me feel safe and calm, including sensory spaces, peer support, and support people.
- My goals for recovery and community participation are respected, and services support me to live as independently and fully as possible.
- I am supported to express my needs and participate in decisions, including through interpreters, communication aids, or IMHA advocates if needed.
- I can give feedback or make complaints about restrictions, and I see that my voice leads to change.
- I am not subject to restrictive practices unless all other reasonable options have been explored and tried. If they are used, they end as soon as they are no longer necessary.

4. How might **carers, families and supporters** experience this principle?

When the least restrictive principle is applied in practice, as a carer, I feel confident that:

- The rights, dignity and autonomy of the person I care for are upheld. Compulsory assessment or treatment or restrictive practices are only used as a last resort.
- The care team works alongside the person I support to explore options that reflect their preferences and support their recovery in the least restrictive way possible.
- Any restrictions used are carefully reviewed, short-term, and guided by what matters most to the person I support - not by what is easiest or most convenient for the system.

5. How do **treating teams** put this principle into practice?

This section gives an overview of requirements and good practice suggestions for putting the least restrictive principle into practice. As noted earlier in this guidance, the dignity and autonomy and supported decision making principles underpin all other principles and must always be considered.

Explore the key topics covered in this section:

- Promote autonomy, choice and supported decision making
- If compulsory treatment is considered, prioritise the patient's views and preferences to understand what is least restrictive
- Promote leave from an inpatient environment where preferred and appropriate
- Reduce and eliminate restrictive practices
- If a restrictive intervention is used, follow Act requirements

Promote autonomy, choice and supported decision making

Requirements include:

- Provide appropriate supports to help people understand information and their rights, to exercise their rights and make and communicate decisions. See dignity and autonomy principle.
- Presume capacity and seek informed consent to treatment, using supported decision making mechanisms including advance statements of preferences, nominated support persons, IMHA advocacy and, with consent, support from carers, families, supporters and kin. See supported decision making and family and carers principles.
- Use recovery-oriented, trauma-informed practice approaches. For example, promote choice over as many decisions as possible, be aware of the likelihood that people accessing mental health and wellbeing services have previous experiences of trauma including trauma within those services and ask what people need to be and feel safe.

Good practice may include:

- Ask consumers if they would like to involve lived and living experience staff in care and treatment discussions. For example, to help the consumer identify treatment approaches that work for them and work towards voluntary engagement as far as possible.
- Ask Aboriginal consumers if they would like to involve Aboriginal mental health workers and Social and Emotional Wellbeing (SEWB) workers in their treatment. For example, to help ensure that connection to Culture is considered as a core part of decisions about what is least restrictive, and to promote voluntary treatment. See cultural safety principle.

> "Least restrictive treatment means treatment that is most in line with what the consumer wants."

If compulsory treatment is considered, prioritise the patient's views and preferences to understand what is least restrictive

Criteria for compulsory assessment and treatment (summarised from ss 142-143 of the Act)

Compulsory assessment and treatment must only be used where all the following criteria apply:

- a person has (or, for assessment orders, appears to have) mental illness
- because the person has (or, for assessment orders, appears to have) mental illness, they need immediate treatment to prevent serious deterioration in their mental or physical health or serious harm to themselves or to another person
- if they are made subject to an assessment, temporary treatment or treatment order, they can be assessed or immediately treated, respectively
- there are no less restrictive means available to enable the person to be assessed or immediately treated.

Requirements include:

Deciding whether a person has mental illness and needs immediate treatment are matters for clinical judgment. However, an assessment of whether there are no less restrictive means available to enable a person to be assessed or immediately treated requires decision-makers to give proper consideration to the person's views and preferences about assessment and treatment while exploring what 'least restrictive' may mean for the person. For example, by:

- speaking with the person
- checking any advance statement of preferences
- speaking with a nominated support person to understand the views of the person who may be assessed or treated
- speaking with families, carers and supporters, and
- checking for any information the service may already have from previous contacts, about what the person would prefer.

Services must be able to show how the person's views and preferences have been considered in decisions around compulsory assessment and treatment. For example, if making a decision about compulsory treatment, the authorised psychiatrist must:

- Give proper consideration to the decision making principles for treatment and interventions set out in Part 3.1 of the Act. For example, consider and explore with the person as far as possible, the impact of compulsory assessment or treatment or restrictive interventions on their relationships, living arrangements, work or study (see Alex scenario in Part One on pages 18-20).
- Consider as far as reasonable in the circumstances:
  - the patient's views and preferences about treatment (including those expressed in an advance statement of preferences, and/or as communicated by their nominated support person) and the reasons for them, including any recovery outcomes the patient would like to achieve.
  - any beneficial alternative treatment that is reasonably available
  - the views of the patient's guardian, parent (if the person is under 16), or carer if the decision will affect the carer and care relationship[9]
  - any other relevant information (see s 180(2)).
- If making a treatment decision for a patient, the authorised psychiatrist must consider the above matters and:
  - the likely consequences for the patient if the treatment is not administered
  - the likely consequences if the treatment is provided to the patient without the patient's consent
  - any second psychiatric opinion that has been given to the authorised psychiatrist (s 89(4)).

9 And the Secretary DFFH if they have parental responsibility for a child under a relevant child protection order.

- Work with the person and (with consent) their family, carer, supporters and kin to meet their preferences wherever possible. For example, preferences about treatment:
  - type - private or voluntary assessment or treatment if preferred/applicable
  - options - talking therapies, groups, preferences about medication type, administration method and dosage
  - environment - community, inpatient or PARC, general inpatient or intensive care area. See also diversity of care and dignity of risk principles.
- With the consumer and (with consent) their family, carer, supporters and kin, with a focus on the consumer's recovery goals and treatment preferences, regularly review any restrictions of the person's rights, dignity and autonomy with a plan to move towards less restrictive treatment (s 79, care and transition to less restrictive support principle).
- When making decisions, remember that the least restrictive principle must be considered in the light of other principles of the Act that emphasise consumer choice and autonomy. If a person and their carer or supporters have different views about what is least restrictive for the person, the person's views have more weight.

Good practice may include:

- Offer timely, prompt opportunities to repair, debrief and discuss compulsory treatment decisions with the consumer and their chosen supporters, with a trauma lens.

Avoid the following practices:

- Avoid using community-based compulsory treatment orders as a default pathway to discharging a person from inpatient care. Rather, discuss with the person and their chosen supporters, available options for voluntary treatment in the community.
- Avoid using compulsory or inpatient assessment or treatment as the default pathway to care without exploring other options. For example, do not require a person to attend an Emergency Department (ED) for assessment without considering community-based assessment.
- Do not ignore less restrictive options that are suggested by the person or their family/carers without considering those options - for example, private or voluntary treatment.
- Avoid varying community-based orders to inpatient orders solely for the purpose of administering medication, as much as possible. Less restrictive alternatives, including working with the person about treatment options they would agree to, must be thoroughly considered before taking this approach. Document any steps taken to try or consider these alternatives, and advise people of their rights to appeal their order to the Mental Health Tribunal, and to access legal assistance including from VLA's Mental Health Legal Rights Service Helpline, the Mental Health Legal Centre or the Victorian Aboriginal Legal Service.

Promote leave from an inpatient environment where preferred and appropriate

Requirements include:

- Promote leave from the inpatient unit where this is in line with the person's preferences and risk and safety assessments. In making decisions about leave for a compulsory patient, the authorised psychiatrist must consider: the purpose of the leave, the need to ensure the health and safety of the person and safety of any other person, the need to minimise the risk of serious harm, the patient's views and preferences about leave, including any views and preferences expressed in an advance statement of preferences or on the patient's behalf by their nominated support person, the role of leave in promoting the patient's recovery outcomes, and the views of any guardian, carer (if the decision will affect carer and care relationship), or parent of a patient aged under 16.[10]

10 Or Secretary DFFH if they have parental responsibility for the person under a relevant child protection order.

- In decisions about leave, consider the interaction with other mental health and wellbeing and decision making principles. The following are examples only of how this interaction may apply:
  - the autonomy principle of the decision making principles, dignity and autonomy, supported decision making and dignity of risk: what are the person's preferences? How is their right to decide to take reasonable risks to achieve personal growth, self-esteem and overall quality of life being supported?
  - consequences of compulsory assessment and treatment and restrictive interventions: what is the impact of the decision about leave on their relationships, living situation, work and study?
  - cultural safety: what is the impact of the leave on the person's ability to stay connected to their culture?
  - health needs: does the person need leave to attend medical appointments?
- Decisions about leave for voluntary patients can be complex. Voluntary patients are free to leave hospital when they choose as long as their absence is discussed with nursing staff before leaving the ward so their whereabouts is known. It may be reasonable to ask a voluntary patient not to leave an inpatient unit until a psychiatrist has assessed their mental state and level of risk. If the person chooses to leave regardless, it may be necessary to consider whether the compulsory assessment criteria apply. In those circumstances, services must transparently discuss all options with the consumer and their support people and facilitate access to IMHA advocacy to support the consumer to express their views and ensure their rights are upheld. Take care to ensure voluntary patients do not feel coerced to remain in the hospital.

Reduce and eliminate restrictive practices

Restrictive interventions - Act requirements

Mental health and wellbeing service providers must work to reduce and eliminate restrictive interventions, and must consider the decision making principles when making decisions about restrictive interventions.

Restrictive interventions must only be used if necessary to prevent imminent and serious harm to the person or another person, or, in the case of bodily restraint, to administer treatment or medical treatment. Restrictive interventions must not be used unless all reasonable less restrictive options have been tried or considered and found to be unsuitable.

If a restrictive intervention is no longer necessary to prevent imminent or serious harm or administer treatment or medical treatment, a person who can authorise a restrictive intervention must immediately take steps to end the restrictive intervention. See sections 125 - 139 of the Act for details.

Requirements include:

- Offer education and resources for consumers, carers, families, supporters and kin about restrictive practices and rights. For example:
  - consumer rights - including the need for restrictive practices to be reduced and minimised, and the rights outlined in the dignity and autonomy and supported decision making principles
  - carer rights - including the right to be involved in care and treatment (see family and carers principle), and to be informed of the use of any restrictive practices.

Good practices may include:

- Seek and respond to consumer, carer and family feedback (individually on admission and during treatment, as well as in group settings, such as consumer meetings) about what helps people to feel safe, and act on feedback. For example, have sensory rooms and resources available, enable access to comforts from home.
- Promote and uphold cultural and gender safety, and ensure the diversity of all consumers is respected and welcomed.
- Be aware that feeling safe is individual. People's individual attributes, including intersecting attributes, will mean that every environment will affect people in different ways.
- Create opportunities for consumers to participate in social, cultural and educational activities to help alleviate feelings of boredom and isolation.
- Be transparent about what may lead to a consumer being subject to restrictive practices. When sharing this information, emphasise that restrictive practices are to be avoided wherever possible, and invite collaboration about what approaches work best for the person.

If a restrictive intervention is used, follow Act requirements

Requirements include:

- If considering a restrictive intervention, delay if possible, to give the person time to self-regulate. If this does not occur, before authorising a restrictive intervention, consider to the greatest extent possible:
  - the likely impact on the person considering their views, preferences and trauma history. This could include previous experiences in mental health and wellbeing services including restrictive practices, as well as trauma from physical or sexual abuse, neglect, war, refugee and migrant experiences, or other traumatic experiences.
  - the person's views and preferences about restrictive practices including any expressed in an advance statement of preferences or as represented by their nominated support person.
  - the person's culture, beliefs, values and personal characteristics. For example, consider the impact of a woman with a history of sexual assault being restrained by multiple male staff.
- Give proper consideration to the decision making principles for treatment and interventions set out in Part 3.1 of the Act.
- Clearly document any interventions or techniques used to try to respond to the person's known preferences to avoid using restrictive practices and to use them only as a last resort. Explain what informed any use of a restrictive intervention.
- Ensure that a person is released from a restrictive intervention as soon as it is no longer necessary to achieve a permitted purpose (for example, to prevent imminent and serious harm to the person or another person, or, in the case of bodily restraint, to administer treatment or medical treatment - s 127).
- Debrief with consumers (with support from their IMHA advocate, nominated support person, family member, carer or other supporter if they prefer) after any restrictive intervention to offer support for any trauma experienced and to gather feedback to improve practices. Consider the environment where the debriefing occurs. Ask the consumer's preferences - for example, to be in a quiet place, away from the unit in which the restrictive intervention was used.
- Comply with the requirements of the Chief Psychiatrist's *Guideline for restrictive interventions* (Department of Health 2024a) and *Reporting directive for restrictive interventions* (Department of Health 2024b).

Avoid the following practices:

- Avoid administering treatment without consent to keep a person calm, especially without using multiple strategies to give the person an opportunity to give informed consent to treatment.
- Do not use restrictive practices for non-permitted purposes - for example, to remove a person's mobile telephone.
- Avoid using restrictive practices solely to prevent a person from leaving an inpatient unit. Restrictive practices can only be used to prevent a person leaving an inpatient unit if there is concern that leaving the unit may result in imminent and serious harm to that person or another person.

Tips for talking about least restrictive treatment with a consumer

Be curious about the person's preferences, needs, strengths and supports.

Ask if they have an advance statement of preferences, nominated support person or other supporter.

Questions may include:

- *What is important to you about your treatment and recovery (for example, type or location of treatment)? What works well for you or makes things hard?*
- *What helps you understand information and make decisions?*
- *Who would you like to be involved in supporting you? Who and what is important in your life - family, connection to culture and community, wellbeing of children or dependents, work?*
- *How can we help you feel safe?*
- *Are there things that you don't like that we can try to avoid? For example, lots of people talking to you at once, crowded space, noise, bright lights, not being able to go outside.*
- *What helps you when things aren't going well? For example, peer support, maintaining regular contact with support people, sensory tools and supports or comforts from home.*
- *How do different restrictions affect you?*

Consider the environment and what the person's verbal and non-verbal communication is showing when having these discussions - for example, is the environment private? Noisy/overstimulating? Restrictive? What do the person's words or body language say?

6. How might **services reflect** on practice?

- How do we prioritise voluntary and/or community-based treatment and engagement? What works well, that we can do more of?
- How do we understand what each consumer sees as least restrictive (according to their own views, values, needs and preferences)? Do we always ask?
- What gets in the way of us providing less restrictive treatment (for example, difficulties in service access meaning people are acutely unwell on admission and during an inpatient stay, bed pressures, short stays, lack of training, workforce availability overnight, poor unit design, lack of sensory rooms, and differing views about risk and restrictiveness)? What can we change?
- If compulsory treatment is used, how do we understand whether and how it is helping the person to work towards their treatment and recovery goals? How can compulsory treatment be minimised?
- What helps us to avoid using restrictive practices? For example, understanding the person's preferences via advance statements of preferences, seeking their direct advice, advice from carers, families and supporters, availability of comforts from home, access to sensory rooms, resources and tools. How can we build on these strengths?
- How do we make sure consumers, and their support people, understand their rights if restrictive practices are used?

7. **Scenario:** Supporting a person in distress[11]

What happened?

Mark, an older man, was an inpatient. On this day several staff were off with the flu, some were agency, and less people available on shift. After a phone call with a family member, Mark became visibly upset and started shouting and throwing things. Staff could see other consumers withdrawing from the communal area. Staff asked Mark to calm down, and suggested he return to his room, but this approach wasn't helpful for him. More staff gathered in the area asking Mark to stop yelling.

What actions did the service take?

One staff member could see that the approaches being used weren't helping and they spoke to the Associate Nurse Unit Manager (ANUM). The ANUM asked staff to give Mark some space, approached him calmly and invited him outside for a chat - 'what's happening? Let's talk.' Mark was still shouting and throwing things. The ANUM explored how Mark was feeling and then validated his experiences.

The ANUM asked Mark if he would like to step outside or sit here in a quieter space. Mark chose to go outside with the ANUM and chatted on the lawn. After a chat with the ANUM, Mark came back inside calmer and not agitated or distressed. Another staff member asked Mark if he wanted a supporter called. Mark and the ANUM talked about what Mark had found helpful while he was distressed, and noted this together in Mark's file.

The staff member who had asked the ANUM for advice reflected later they had been afraid Mark's behaviour would continue to escalate, leading to more restrictive approaches. By listening and validating his distress, and encouraging Mark to go outside for fresh air and a chat, he felt supported and was able to re-enter the ward in a much better frame of mind.

The ANUM also used this as an opportunity to arrange for refresher education for staff around working with distress, including reminding staff about Safewards interventions, and reminded all staff about quick tools that could be referred to on the service intranet.

Reflections from Commission lived and living experience staff

A lot of us can go from zero to 100 quickly, depending on our circumstances. It is a great gift when people can help hold us in our distress. Here, the ANUM connected gently and led with kindness. They were mindful of where Mark was at emotionally, which helped them to see him and his distress, rather than focusing only on his language and actions.

Which other principles were engaged?

Mental health and wellbeing principles: Dignity and autonomy, supported decision making

Decision making principles: Consequences of compulsory assessment and treatment and restrictive interventions principle

How would you approach this situation?

What might you do differently?

11 Note: The scenarios in this guidance are adapted from real examples. These simple scenarios focus on the application of one principle and are intended to show that applying the principles is not always complicated. Scenarios that address the principles in more complex situations and ways are available in implementation resources on the Commission's website

8. Where can I find **more information?**

Australian Commission on Safety and Quality in Healthcare (2021) *National Safety and Quality Health Service Standards* https://www.safetyandquality.gov.au/standards/nsqhs-standards

Department of Health (2013) *Providing a safe environment for all: framework for reducing restrictive interventions* https://www.health.vic.gov.au/practice-and-service-quality/framework-for-reducing-restrictive-interventions

Department of Health (2024a) *Restrictive interventions: Chief Psychiatrist's guideline* https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions

Department of Health (2024b) *Chief psychiatrist's reporting directive for restrictive interventions* https://www.health.vic.gov.au/chief-psychiatrist/chief-psychiatrists-restrictive-interventions

Department of Health (2025a) *Understanding and reporting chemical restraint: a factsheet for prescribing clinicians* https://www.health.vic.gov.au/chief-psychiatrist/understanding-reporting-chemical-restraint

Department of Health and Human Services (2016) *Safewards handbook: training and implementation resource for Safewards in Victoria* https://www.safercare.vic.gov.au/sites/default/files/2025-04/Safewards%20Victoria%20Handbook%202016.pdf and associated resources

Department of Health and Human Services (2019a) *Mental Health Intensive Care Framework* https://www.safercare.vic.gov.au/publications/mental-health-intensive-care-framework

Safer Care Victoria (2025) resources Working towards the elimination of restrictive practices in inpatient services | Safer Care Victoria https://www.safercare.vic.gov.au/best-practice-improvement/mental-health-improvement-program/initiatives/elimination-of-restrictive-practices

Reducing compulsory treatment in Victorian Mental Health and Wellbeing Services | Safer Care Victoria https://www.safercare.vic.gov.au/best-practice-improvement/mental-health-improvement-program/initiatives/reducing-compulsory-treatment