Mental Health Act 2016
Chief Psychiatrist Policy

Seclusion

Contents

General

Seclusion is the confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented. Seclusion significantly affects patient rights and liberty and therefore can only be authorised as a last resort to prevent imminent and serious risk of harm to patients and staff, where less restrictive interventions have been unsuccessful or are not feasible.

The *Mental Health Act 2016* (the Act) makes provision for a range of safeguards and restrictions in relation to the use of seclusion in an authorised mental health service (AMHS). In line with national approaches, this policy supports the reduction and elimination of seclusion for patients.

It is an offence to seclude a person in an AMHS other than in accordance with the Act.

AMHSs **must** comply with a written direction given by the Chief Psychiatrist about seclusion.

The following principles **must** be applied in the use of seclusion:

- maintaining the safety, wellbeing and dignity of the patient is essential,
- protecting the safety and wellbeing of staff is essential,
- seclusion should only be used for the minimum period of time necessary, and
- all staff actions should be justifiable and in proportion to the patient's behaviour and broader clinical context.

Scope

This policy is mandatory for all AMHSs. An authorised doctor, authorised mental health practitioner, AMHS administrator, or other person performing a function or exercising a power under the Act **must** comply with this policy.

Staff should work collaboratively and in partnership with individuals in their care to ensure their unique age-related, cultural and spiritual, gender-related, religious and communication needs are recognised, respected and followed to the greatest extent practicable. This should include the timely involvement of appropriate local supports and a recovery-oriented focus.

This policy **must** be implemented in a way that is consistent with the objects and principles of the Act.

This policy is issued under section 305 of the *Mental Health Act 2016*

Dr John Reilly
Chief Psychiatrist, Queensland Health
15 October 2021

Policy

1 Application of seclusion provisions

Key points

- The seclusion provisions of the Act may only be applied to a **relevant patient** in an AMHS.
- In relation to the seclusion provisions, a relevant patient is:
  - A patient in an AMHS, subject to a Treatment Authority, Forensic Order (Mental Health or Disability) or Treatment Support Order, or
  - A person who is absent without permission from an interstate mental health service and who has been detained in an AMHS.
- A person detained for examination or assessment, or patients who are accessing mental health services voluntarily or with the consent of a substitute decision-maker **cannot** be placed in seclusion under the Act.
- Seclusion may be authorised in any unit within an AMHS, including an emergency department, provided the room or area complies with this policy and sufficient resources are available to safely meet the needs of the patient.
- Seclusion of a relevant patient under the Act must be recorded on the patient's clinical record in CIMHA (see section 6.2 Recording).

Mechanical restraint **must not** be used on a patient in seclusion.

When using seclusion under the Act, staff **must** do all of the following:

- Use verbal strategies, de-escalation techniques and other evidence-based strategies such as sensory modulation to help the patient safely gain control of their behaviour,
- Be appropriately trained to protect the welfare, dignity and safety of the patient. Training must include de-escalation strategies, trauma-informed care, recovery-oriented practice, de-briefing strategies and the use of seclusion,
- As far as practicable in the circumstances, explain to the patient the reason for seclusion, what will happen during the seclusion (such as clinical observations, access to food and drink, access to the toilet), and the circumstances in which they may be removed from seclusion.

1.1 Seclusion-type management of persons other than a relevant patient

The Act only enables seclusion to be authorised for **'relevant patients'.**

By exception, there may be urgent circumstances where a person other than a relevant patient requires seclusion-type management (e.g. containment in a room from which the person cannot leave). In these circumstances, other legal frameworks and mechanisms authorising the use of seclusion-type management (e.g. the *Guardianship and Administration Act 2000*) should be used in line with local and Hospital and Health Service policies and procedures. Management of individuals in this way should only be considered as a matter of last resort.

A record of such an event **must** be made on the patient's clinical record (clinical note/progress note) if the event occurs:

- in a mental health inpatient or other specialist mental health unit of an AMHS, or
- in another area of an AMHS (for example, an Emergency Department) where mental health service staff are involved in the seclusion-type management.

Escalation within the service as a significant event and/or notification to the Chief Psychiatrist of suspected significant non-compliance with the Act should also be considered (refer to the *Chief Psychiatrist Policy Notification to the Chief Psychiatrist of critical incidents and significant non-compliance with the Mental Health Act 2016*).

Where a person in a mental health inpatient unit, who is not a relevant patient, is subject to seclusion-type management, an assessment by an authorised doctor should also occur as soon as possible, to determine whether the person satisfies the criteria for treatment and care under the *Mental Health Act 2016* and whether to implement appropriate actions e.g. provision of treatment under a Treatment Authority.

2 Emergency authorisation of seclusion

Key points

- A health practitioner in charge of a unit (see definitions) within an AMHS may initiate an emergency authorisation of seclusion of a relevant patient for up to **one (1) hour**, if satisfied that:
  - it is not practicable for an authorised doctor to authorise the seclusion (e.g. the authorised doctor is not immediately available),
  - there is no other reasonably practicable way to protect the patient or others from physical harm, and
  - the seclusion complies with a written direction about seclusion from the Chief Psychiatrist (where a direction has been given).
- Emergency seclusion must not be authorised if the total period of emergency seclusion is, or will reach under the authorisation, more than **three (3) hours within a 24-hour period**.
- A total of **three (3) hours in a 24-hour period** may be reached when a patient is secluded on a number of separate occasions of up to **one (1) hour** each (totalling **three (3) hours**), or when a patient has been secluded three times consecutively for **one (1) hour** each time.
- Consecutive use of emergency authorisations of seclusion should only be used in exceptional circumstances.

During emergency seclusion, the patient **must** be continuously observed.
CCTV is **not** a sufficient way to continuously observe a patient in seclusion.

2.1 Health practitioner in charge of a unit responsibilities

Key points

- To authorise seclusion in an emergency, the health practitioner in charge **must** complete the *Emergency Authorisation of Seclusion form* as soon as practicable after caring for the patient.
  - The *Emergency Authorisation of Seclusion form* **must** be completed electronically on CIMHA or, if this is not practicable, completed in hard copy and uploaded to CIMHA.
- The health practitioner in charge **must** notify the authorised doctor, as soon as practicable after the start of seclusion.
- This notification **must** occur via a phone call or face to face and cannot be done via email or instant messaging notification.

The health practitioner in charge may remove the patient from seclusion prior to the end of the emergency authorisation period if satisfied the seclusion is no longer necessary to protect the relevant patient or others from physical harm.

If the patient is released from seclusion prior to the end of the emergency authorisation period, the authority to seclude the patient ends. If the patient requires emergency seclusion again, a new *Emergency Authorisation of Seclusion form* **must** be completed.

2.2 Authorised doctor responsibilities

Key points

- The authorised doctor that is notified of the emergency seclusion **must**, as soon as practicable:
  - examine the patient, or ensure the patient is examined by another authorised doctor, and
  - determine whether seclusion should be authorised for the patient.
- If seclusion is to be authorised by the authorised doctor, an *Authorisation of Seclusion form* must be completed.

Any period the patient has spent in seclusion under the emergency authorisation **must** be included when determining the total period for which the patient has been secluded within a **24-hour** period.

The patient **must** be examined by an authorised doctor even if the patient is removed from emergency seclusion **before one (1) hour** has elapsed or before the doctor's arrival.

The doctor's examination **must** be recorded in the patient's clinical record. Wherever possible this should be in CIMHA.

3 Process for authorising seclusion

Seclusion may be authorised for up to **three (3) hours** at a time by an authorised doctor by completing the *Authorisation of Seclusion form* on CIMHA.

An authorised doctor's order for seclusion **must** be based on a face-to-face medical review of the patient and cannot be made in advance (i.e. in anticipation that seclusion may be required). This review **must** occur even if consecutive authorisations are made by the same authorised doctor.

Appendix 1 contains an example of the process for authorising seclusion.

3.1 Authorised doctor responsibilities

Key points

- The authorised doctor **must** be satisfied that:
  - there is no other reasonably practicable way to protect the patient or others from physical harm,
  - the seclusion complies with this policy,
  - the seclusion complies with a written direction about seclusion from the Chief Psychiatrist (where a direction has been given), and
  - the seclusion complies with an approved *Reduction and Elimination Plan (R&E Plan)* (where a *R&E Plan* is in place).
- The *Authorisation of Seclusion form* **must** include:
  - the duration of the seclusion, including start and finish times, which must not exceed **three (3) hours**,
  - specific measures to ensure the health, safety and comfort of the patient,
  - observation requirements while the patient is in seclusion (see section 3.2 Observation of patients in seclusion), and
- whether a health practitioner may remove the patient from seclusion before the authorised period ends.

When authorisation for a period of seclusion has expired, further time in seclusion requires a new authorisation.

Each authorisation **must** be completed on the *Authorisation of Seclusion form* on CIMHA and **must** include the information detailed above.

A patient's total hours in seclusion **must not** exceed **nine (9) hours in a 24-hour period**.

A total of **nine (9) hours in a 24-hour period** may be reached when a patient is secluded on a number of separate occasions of up to **three (3) hours** each (totalling nine (9) hours), or when a patient has been secluded three times consecutively for **three (3) hours** each time.

A 24-hour period commences from the first time the patient is placed in seclusion. This includes time spent in seclusion under an *Emergency Authorisation of Seclusion* (see section 2 Emergency authorisation of seclusion).

If necessary, seclusion may be authorised for more than **nine (9) hours in a 24-hour period** only if approved under a *R&E Plan* (see sections 3.5 Extension of period of seclusion and 4 Reduction and Elimination Plans).

3.2 Observation of patients in seclusion

Observation of a patient in seclusion **must** be continuous or at intervals of no more than **fifteen (15) minutes**. This **must** be determined by the authorised doctor based on clinical assessment.

CCTV **is not** a sufficient way to continuously observe a patient in seclusion.

Patient care and observation requirements **must** be documented on the *Authorisation of Seclusion form* on CIMHA.

Where an authorised doctor authorises seclusion and determines that continuous clinical observations for a patient in seclusion is not clinically appropriate, the relevant clinical background and rationale for this decision should be recorded on the patient's clinical record, including on CIMHA.

Clinicians should refer to the *Therapeutic Visual Observation Guidelines for Mental Health Alcohol and Other Drugs Services* for information on relevant clinical considerations when determining the frequency of observations.

3.2.1 Considerations for vulnerable persons

If seclusion is required, consideration should be given to the vulnerabilities of persons at higher risk for trauma, harm/suicide (e.g. minors, persons of Aboriginal and/or Torres Strait Island descent, victims of torture, or refugees) to determine whether continuous observation is clinically appropriate for the person. This should include consultation with appropriate support persons. In this context an appropriate support person is:

- an appropriate family member,
- a cultural support person,
- an Aboriginal or Torres Strait Islander health or peer support worker, or
- for a minor – a parent[1].

Wherever possible, a shared position on observation requirements should be reached between clinical teams and the appropriate support person/s for the patient. However, the treating team is ultimately responsible for making decisions on observation requirements as clinically appropriate.

Any decision that continuous clinical observations are not appropriate should be considered with and approved by the consultant psychiatrist responsible for clinical care and documented on an approved R&E Plan. If there is no R&E Plan, the decision should be made by the consultant psychiatrist on the first occasion on any day on which seclusion occurs.

The rationale for decisions on observation requirements for vulnerable persons should be recorded on the patient's clinical record in CIMHA, including whether support was sought from a support person.

In circumstances where a peer support worker or health worker is involved in the decision making, the worker will record relevant considerations discussed on the patient's clinical record in CIMHA.

3.3 Health practitioner in charge of unit responsibilities

The health practitioner in charge of the unit has responsibilities to ensure the authorisation of seclusion is complied with. This includes meeting observation requirements and ensuring any specific measures required by the authorised doctor for the patient's health and safety are carried out.

[1] Under the Act, a parent includes a guardian of the minor, or a person who exercises parental responsibility for the minor, other than on a temporary basis, or for minors of an Aboriginal background, a person who, under Aboriginal tradition, is regarded as a parent of the minor, and for a minor of Torres Strait Islander background, a person who, under Island custom, is regarded as the parent of the minor.

3.4 Restrictions on authorisations

Authorisation for a relevant patient to be in seclusion **must not** be provided if the patient's total time in seclusion is, or will reach under the authorisation, more than **nine (9) hours** in a **24-hour** period unless:

- an approved R&E Plan for the patient provides for seclusion in excess of **nine (9) hours** in a **24-hour** period (see section 4 Reduction and Elimination Plans), or
- a seclusion extension has been approved by the clinical director of the unit where the seclusion is taking place.

The Administrator of the AMHS **must** ensure that a local process is implemented within the AMHS to ensure that the actual time a patient spends in seclusion is able to be readily calculated.

3.5 Extension of period of seclusion

A single extension to seclusion of up to **twelve (12) additional hours** may be made when:

- seclusion has or is likely to exceed **nine (9) hours** in a **24-hour** period, and
- an approved R&E Plan is not yet in place.

The purpose of the extension is to allow for the development and approval of a R&E Plan

An extension requires:

- the approval of the clinical director (or their delegate), and
- authorisation by an authorised doctor.

An *Authorisation of Seclusion form* **must** be completed for each period of seclusion under an extension in accordance with section 3.1 Authorised doctor responsibilities. See also Attachment 1 – Seclusion scenario examples.

3.5.1 Authorised doctor responsibilities

Key points

- In making an extension of seclusion the authorised doctor **must** be satisfied that:
  - the clinical director (or delegate) of the AMHS has given written approval for the extension,
  - there is no other reasonably practicable way to protect the patient or others from physical harm,
  - the seclusion complies with this policy,
  - the seclusion complies with a written direction about seclusion from the Chief Psychiatrist (where a direction has been given), and
  - it has not been reasonably practicable for a *R&E Plan* to be approved during the **nine (9) hours**.
- The *Extension of Seclusion form* **must** be completed electronically in CIMHA or, if this is not practicable, completed in hard copy and uploaded to CIMHA. The authorised doctor **must** include:
  - the period for which seclusion is to be extended, including start and finish times, which **must not** be more than **twelve (12) hours**,
  - specific measures to ensure the health, safety and comfort of the patient,
  - observation requirements for the extension period, and
  - whether a health practitioner may remove the patient from seclusion before the authorised period ends.
- The clinical director's written approval is to be provided on the *Extension of Seclusion form*.

If it is likely that an *Extension of Seclusion* will be required (e.g. it is late evening, a patient has been in seclusion for **seven (7) hours** within the **24-hour** period and it has not been possible to complete a R&E Plan), the *Extension of Seclusion* can be completed before it is required; provided this occurs within a reasonable timeframe and is for the purposes of providing appropriate treatment and preventing expiration of the seclusion authority.

In urgent circumstances the clinical director may provide initial approval via email following a telephone discussion with the authorised doctor and receipt of an email from the authorised doctor containing:

- relevant clinical details regarding the patient,
- specific measures to ensure the health, safety and comfort of the patient, and
- the reasons for use of seclusion.

An *Extension of Seclusion form* **must** be provided to the clinical director for approval as soon as practicable and within **24-hours** of the email approval being provided.

The approval of an *Extension of Seclusion* **does not** replace the requirement for authorisation of each individual period of seclusion.

While the patient remains secluded, an *Authorisation of Seclusion form* and a medical review by an authorised doctor **must** be undertaken every **three (3) hours**. The medical review should include a physical examination (if clinically appropriate and safe to do so) and **must** consider whether seclusion should be continued or ceased.

3.5.2 Health Practitioner in charge of unit responsibilities

The health practitioner in charge of the unit has responsibilities to ensure the seclusion authorisation is undertaken as directed. This includes meeting observation requirements and ensuring any specific measures required by the authorised doctor for the patient's health and safety are carried out.

4 Reduction and Elimination Plans

A *Reduction and Elimination Plan (RE Plan)* outlines measures to be taken to reduce and eliminate the use of seclusion for a patient and to reduce the potential for trauma and harm.

The R&E Plan reinforces efforts to proactively reduce the use of seclusion for a patient by ensuring clinical leadership, monitoring, accountability and a focus on safe, less restrictive alternatives.

4.1 Requirements for Reduction and Elimination Plans

Key points

- It is recommended practice for a *R&E Plan* to be in place in all instances where a patient is secluded, in particular where multiple instances of seclusion occur.
- An approved *R&E Plan* **must** be in place for any patient who is secluded for more than **nine (9) hours in a 24-hour period**.
  - Development of a *R&E Plan* should be initiated in advance if it is considered likely that the seclusion of a patient could exceed **nine (9) hours in a 24-hour period**.
  - The clinical director (or delegate) may approve the first *R&E Plan* required for a patient in an acute management period (see section 4.1.1 Delegation of authority to approve Reduction and Elimination Plan).
  - An authorised doctor **must** apply to the Chief Psychiatrist for approval of any subsequent *R&E Plan*.
    - The Office of the Chief Psychiatrist will review the proposed plan and make a recommendation to the Chief Psychiatrist about its approval.
    - The Office of the Chief Psychiatrist may contact the authorised doctor making the application for further information.
    - The clinical director and authorised doctor will be advised in writing of the Chief Psychiatrist's decision as soon as possible, but within **two (2) working days** of receiving the plan.
- The Chief Psychiatrist may also direct, on their own initiative, that a *R&E Plan* be prepared for a patient.
  - Where a direction is made, the treating doctor and relevant clinical director will be advised of this requirement via telephone and email.
- The *R&E Plan* form is available within the clinical documents via 'online MHA forms' in CIMHA. If the form is not completed on CIMHA, it **must** be completed manually and uploaded onto the patient's clinical record in CIMHA as soon as possible.

In urgent circumstances the Chief Psychiatrist may provide initial approval of a *R&E Plan* via email following a telephone discussion with the authorised doctor and receipt of an email from the authorised doctor containing:

- relevant clinical details regarding the patient,
- the reasons for use of seclusion, and
- the planned use of seclusion and strategies for the reduction and elimination of use.

A full *R&E Plan* **must** be provided to the Chief Psychiatrist within **24-hours** of the email approval being provided.

A *R&E Plan* **must** not be approved for longer than **seven (7) days**. The timeframe for an approved plan **cannot** be extended.

If a patient requires seclusion for a period longer than **seven (7) days**, a new *R&E Plan* **must** be submitted to the Chief Psychiatrist for approval.

A clinical director **cannot** approve subsequent *R&E Plans* (see section 4.1.1 Delegation of authority to approve Reduction and Elimination Plan).

Key points

- A *R&E Plan* must be recorded on the patient's clinical file and **must** include the following details:
  - the name and date of birth of the patient
  - the name of the AMHS
  - any previous use of seclusion for the patient
  - any strategies previously used to reduce the use of seclusion for the patient and the effectiveness of the strategies
  - a description of the behaviour that has led to the proposed seclusion
  - a description of significant risks to the patient or others
  - the reasons that the authorised doctor believes there is no other reasonably practicable way to protect the patient or others from physical harm
  - the proposed frequency and duration of seclusion for the duration of the *R&E Plan*
  - the strategies proposed to reduce and eliminate the use of seclusion.
- The approval of a *R&E Plan* **does not** replace authorisation of each individual period of seclusion.
- An *Authorisation of Seclusion form* and a medical review **must** be completed by an authorised doctor every **three (3) hours**.

A single *R&E Plan* may apply to **both** mechanical restraint and seclusion.

Only the Chief Psychiatrist may approve a *R&E Plan* that covers both seclusion and mechanical restraint, or mechanical restraint alone.

Seclusion and mechanical restraint **must not** be used simultaneously.

4.1.1 Delegation of authority to approve Reduction and Elimination Plan

The Chief Psychiatrist may delegate the authority to approve a *R&E Plan* for seclusion to the clinical director (or another senior clinician of the AMHS).

- The clinical director (or delegate) may only approve the first *R&E Plan* required for a patient in an acute management period.
- Subsequent plans must be approved by the Chief Psychiatrist.

An acute management period is an acute phase during an admission, in which seclusion for more than **nine (9) hours** in a **24-hour** period may be necessary.

5 Removal from seclusion

Key points

- An authorised doctor **must** remove a patient from seclusion prior to the end of an authorisation period if satisfied the seclusion is no longer necessary to protect the patient or others from physical harm.
- A health practitioner **must** remove a patient from seclusion if:
  - the authorised doctor has stated that a health practitioner may remove the patient from seclusion before the authorised period ends in the *Authorisation of Seclusion form* or *Extension of Seclusion form*, and
  - the health practitioner is satisfied the seclusion is no longer necessary to protect the patient or others from physical harm.

Except for emergency seclusion, if the patient is removed from seclusion prior to the authorisation ending, they may be returned to seclusion under the same authorisation if necessary, to protect the patient or others from physical harm.

This movement in and out of seclusion must be documented on the *Return to and release from seclusion form* which should then be uploaded onto the patient's clinical record on CIMHA.

A break in a patient's seclusion or release from seclusion **does not** include circumstances where another person (such as an authorised doctor) enters, or the patient is removed from, the seclusion room for the purpose of meeting the patient's needs. This includes, for example, assisting the patient to access toilet facilities, for the administration of medication or medical review of the patient.

Movement of individuals in/out of seclusion rooms for these purposes **should not** be recorded on the *Return to and release from seclusion form*.

5.1 Removal from seclusion on Chief Psychiatrist direction

The Chief Psychiatrist may also direct an authorised doctor or health practitioner in charge to remove a patient from seclusion if satisfied the seclusion is no longer necessary to protect the patient or others from physical harm.

The authorised doctor or health practitioner in charge **must** comply with this direction.

5.2 Requirements following seclusion

5.2.1 Medical Review of the patient

A medical review of the patient, including a physical examination if clinically appropriate and safe to do so, **must** be undertaken by an authorised doctor at the end of each authorised period of seclusion (e.g. after **three (3) hours** of seclusion, or earlier).

The medical review should occur as soon as practicable after the seclusion period ends and must consider whether seclusion should be continued or ceased.

Note: A doctor is not required to attend in the middle of the night to conduct a medical review unless a further authorisation of seclusion is likely to be required.

The outcomes of the review **must** be recorded in the patient's clinical record, including on CIMHA.

5.2.2 Post-event debriefing

A review (or debrief) with the patient involved in the seclusion (with the patient's consent), and with other patients involved in any event that led to the seclusion, **must** be undertaken as soon as is clinically appropriate after the seclusion ends, in order to:

- enable open discussion about the seclusion, the events leading to it and the patient's experience of it,
- allow the patient to ask questions, and
- provide an opportunity to identify strategies that may assist in preventing the need for seclusion in the future. This may include a written plan or list of strategies that can be shared with and utilised by the patient, their support person(s) and staff.

The review (or debrief) should include support persons such as a family member or peer worker where possible and appropriate.

A review (or debrief) for all staff involved in the seclusion of the patient **must** also be undertaken as soon as practicable after the seclusion ends, to:

- enable open discussion about the seclusion, the events leading to it and the staffs' experience of it,
- identify the triggers which resulted in the need to use seclusion,
- evaluate the success/efficacy of methods used to respond to the event, and
- identify measures to reduce, and where possible, prevent future use of seclusion.

Reviews for patients and staff may require more than one meeting to address different aspects of the seclusion.

6 Notifications and recording

6.1 Notifications

Key points

- The administrator of the AMHS **must** ensure that processes are in place within the AMHS to ensure compliance with the notifications and recording requirements outlined in this policy.
- The clinical director (or appropriately delegated person) **must** notify the Chief Psychiatrist immediately where seclusion results in, or is associated with:
  - the death of a patient during or within **twenty-four (24) hours** following seclusion of the patient
  - significant harm to a patient or other person during seclusion or within **twenty-four (24) hours** following seclusion of the patient.
  - This notification process is in addition to the requirements contained in the *Chief Psychiatrist Policy Notification of Critical Incidents and Non-compliance under the Mental Health Act 2016*.

Notification to the Chief Psychiatrist **must** be made via phone or email.

6.2 Recording

Key points

- Each time a relevant patient is secluded, the health practitioner in charge of the unit **must** ensure the following information is recorded in the patient's clinical record in CIMHA as soon as practicable:
  - the start and end times of each seclusion event, and
  - any *R&E Plan* approved by the Chief Psychiatrist or where delegated, a clinical director of the AMHS, and
  - the *Authorisation of Seclusion form* or *Authorisation of Emergency Seclusion form*, and
  - the *Return to and Release from Seclusion form*.

In addition, the following information must be recorded in the patient's clinical record in CIMHA:

- the reasons for the seclusion, including the events that led to the seclusion
- why there was no other reasonably practicable way to protect the patient or others from physical harm, including any strategies used to prevent the need for seclusion
- the patient's health at the time of the seclusion, including signs of alcohol or drug use or withdrawal
- the patient's behaviour during the seclusion
- whether physical or mechanical restraint directly preceded a seclusion event
- medications administered up to one hour before, during or immediately after the seclusion (medication name, dose, and route of administration)
- any adverse events related to the seclusion (for example, injury to the patient or staff)
- food and fluid intake during the seclusion
- level of visual observations undertaken
- the examinations that took place during and after the seclusion, and
- post-event debriefing of the patient, staff and any other relevant persons.

Seclusion of persons other than patients receiving treatment and care under the Act must be recorded in the patient's clinical record. The Administrator of the AMHS should ensure that procedures are in place to ensure these records are maintained, consistent with *National Safety and Quality Health Service Standards 2nd Edition* in relation to all seclusion-type events.

Further information

Definitions and abbreviations

Term	Definition
AMHS	Authorised Mental Health Service – A health service, or part of a health service, declared by the Chief Psychiatrist to be an authorised mental health service. AMHSs include both public and private sector health services. While treatment and care is provided to both voluntary and involuntary patients, additional regulation applies under the Act for persons subject to involuntary treatment and care.
CIMHA	Consumer Integrated Mental Health and Addiction Application – The statewide mental health database which is the designated patient record for the purposes of the Act.
Clinical director	A senior authorised psychiatrist who has been nominated by the administrator of the AMHS to fulfil the clinical director functions and responsibilities outlined in this policy.
Health practitioner in charge of a unit	A health practitioner in charge is any health practitioner with oversight, in control of or with responsibility for a given unit in an AMHS.
NSP	Nominated support person – A family member, carer or other support person formally appointed by a patient to be their nominated support person. NSP rights include that they: • must be given all notices about the patient that are required under the Act • may discuss confidential information about the patient's treatment and care • may represent, or support the person, in any hearings of the Mental Health Review Tribunal, and • may request a psychiatrist report if the person is charged with a serious offence.
Relevant patient	A patient in an AMHS, subject to a Treatment Authority, Forensic Order or Treatment Support Order, or A person who is absent without permission from an interstate mental health service and who has been detained in an AMHS.
Seclusion	The confinement of a person, at any time of the day or night, alone in a room or area from which free exit is prevented.
Support person/s	Includes, an appointed nominated support person or, if the person does not have a nominated support person, a family member, carer or other support person.

Referenced policies and resources

Chief Psychiatrist policies

- Notification of Critical Incidents and Non-compliance under the Mental Health Act 2016.

Mental Health Act 2016 forms and other resources

- Authorisation of Emergency Seclusion form
- Authorisation of Seclusion form
- Return to and Release from Seclusion form
- Reduction and Elimination Plan
- Therapeutic Visual Observation Guidelines for Mental Health Alcohol and Other Drugs Services
- National Safety and Quality Health Service Standards 2nd Edition

Legislation

- *Guardianship and Administration Act 2000*

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Appendix 1 – Scenarios (Examples only)

SCENARIO One – Seclusion and observations

A patient on a Treatment Authority (community category) becomes acutely unwell and is admitted to an inpatient unit of an AMHS. The patient becomes verbally abusive and threatening towards staff.

The mental health care team attempts to verbally de-escalate and provide the person with time-out in a quiet area to help them de-stimulate. However, the person becomes increasingly agitated and verbally aggressive towards staff. Team members attempt to contact the person's appointed nominated support person who has previously had a calming influence on the person, however, they are unable to be contacted.

The team members attempt to direct the person to the quiet area for a second time-out, when the person begins hitting at and kicking at staff.

The clinical nurse in charge of the inpatient unit requests assistance from health security to help physically restrain the person. The team agree there is no less restrictive way to protect the patient, staff and others from physical harm, and the authorised doctor prepares an Authorisation of Seclusion.

The authorised doctor's clinical assessment of the person determines observations are to occur at fifteen (15) minute intervals and this is included on the form. Clinical background and rationale for this decision is documented on the patient's clinical record (including on CIMHA).

The clinical nurse documents the physical restraint event in CIMHA on the Physical restraint clinical note.

SCENARIO Two – Extension of Seclusion

It is 9:00pm. A patient has been in seclusion for seven (7) hours within a 24-hour period and it has not been possible to complete a *Reduction and Elimination Plan (R&E Plan)*. By 11:00pm, the patient will have been in seclusion for nine (9) hours (the maximum time allowed in a 24-hour period).

An authorised doctor completes an *Extension of Seclusion form* for the 12-hour period from 11:00pm that night to 11:00am the following morning. The extension is approved by the clinical director (or delegate). A *R&E Plan* is developed and approved by the time the extension expires at 11:00am.

SCENARIO Three - Extension of Seclusion (separate acute phase)

A patient admitted to an AMHS on an inpatient order or authority may require seclusion during the first week of the admission while they are acutely unwell. An *Extension of Seclusion* may be authorised once for each phase of the admission in which the patient requires acute management for the purpose of developing a *R&E Plan* for the person.

It is day two of a patient's admission and they have been secluded for eight (8) hours and require further seclusion due to their presentation. An *Extension of Seclusion* is authorised to allow time for the development of a *R&E Plan*. The *R&E Plan* is approved for a three-day period.

The patient's mental state improves, and the patient continues their admission for a further four weeks with no subsequent seclusion events. However, in the fourth week of the admission, the patient's mental state deteriorates, and seclusion is required as part of a planned response to manage behaviours while they are acutely unwell. To allow time for approval of a new *R&E Plan*, an *Extension of Seclusion* is authorised, as it relates to a separate acute 'phase' for the patient.

Note that in this example, two separate acute phases have occurred within a single inpatient admission for the patient, with a clear period of more settled behaviour in between, during which seclusion has not been necessary.

SCENARIO Four – Extension of Seclusion (re-admission)

A patient on an inpatient category order is admitted to an AMHS. During the patient's admission, a period of seclusion is required, an *Extension of Seclusion* is authorised, and a *R&E Plan* is developed. Once stable, the patient is discharged from the inpatient unit.

The patient returns to the emergency department the following day and requires another admission and a further period of seclusion.

In this case and because there are two separate admissions, an *Extension of Seclusion* can be authorised, if required, to enable the development and approval of a new *R&E Plan*.

The timeframes and scenarios outlined above are examples only and other applications of this policy will apply in practice.

The Office of the Chief Psychiatrist should be contacted as early as possible if an authorised doctor or health practitioner in charge of a unit requires advice in relation to the circumstances in which seclusion may be authorised.