



**Queensland
 Government**

Mental Health Act 2016
**Reduction and Elimination Plan
 (Seclusion and Mechanical Restraint)**

(Affix identification label here)

URN:
 Family name:
 Given name(s):
 Address:
 Date of birth: Sex: M F I

Mental Health Act (MHA) 2016, Sections 248, 257(e), 264–267

- **Seclusion:**
 - A patient may not be secluded for more than nine (9) hours in a 24 hour period, unless allowed under an approved Reduction and Elimination Plan, or a seclusion extension has been approved to allow time for the development and approval of a Reduction and Elimination Plan.
 - The Chief Psychiatrist may direct that the seclusion of a patient only occur under a Reduction and Elimination Plan for the patient.
- **Mechanical Restraint:**
 - A patient may not be mechanically restrained for more than nine (9) hours in a 24 hour period, unless allowed under an approved Reduction and Elimination Plan.
 - An application to the Chief Psychiatrist to approve the use of mechanical restraint on a patient may include an application for the Chief Psychiatrist to approve a Reduction and Elimination Plan for the patient.
- **Note:**
 - It is recommended practice for a Reduction and Elimination Plan to be in place in all instances where a patient is secluded or mechanically restrained.
 - A patient must not be simultaneously secluded and mechanically restrained.

1. Person's details

• Not required if label affixed in top right corner.

Surname:		Given name(s):	
Residential address:			
Town / Suburb:		State:	Postcode:
Date of birth:	Age: or	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex / Indeterminate <input type="checkbox"/> Not stated / unknown	

2. Proposed plan approval period

- Plans cannot exceed 7 days.
- This plan does not replace the authorisation of each individual period of seclusion or mechanical restraint by an authorised doctor.
- This plan does not replace the requirement for minimum 3 hourly medical reviews of patients who are secluded or mechanically restrained.

Plan commences	Date:	Time (24hr):	Plan expires	Date:	Time (24hr):
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3. This plan is intended to reduce and eliminate

- Seclusion only**
- Mechanical restraint only** - identify approved restraint device:
- Seclusion AND mechanical restraint** - identify approved restraint device:

4. Treating AMHS and MHA status

Name of treating authorised mental health service (AMHS):

MHA status: Treatment authority Treatment support order Forensic order Detained from interstate

5. Advanced Health Directive (AHD)

Does the consumer have an AHD? Yes - type: No

6. Diagnoses

[Large empty box for entering diagnoses]

DO NOT WRITE IN THIS BINDING MARGIN

V1.00 - 01/2017



SW742

REDUCTION AND ELIMINATION PLAN (SECLUSION AND MECHANICAL RESTRAINT)



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7. Current mental state and risk issues, relevant clinical history and current treatment

8. Reasons for use of seclusion or mechanical restraint, and why less restrictive interventions are not sufficient

- Include details about behaviours of concern and known triggers.

9. Physical health

- Include details about existing medical conditions and treatments, physical impairment, smoking status, recent medication changes.

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10. Special considerations and alerts

- Include risks associated with use of seclusion or mechanical restraint (e.g. age, previous traumatic experience, culture, pregnancy, medical condition etc.).

Empty text area for special considerations and alerts.

11. Previous (recent) use of seclusion or mechanical restraint

- Note frequency and duration of use most relevant to this Plan.

Empty text area for previous use of seclusion or mechanical restraint.

12. Any strategies previously trialled to reduce or prevent seclusion or mechanical restraint, and the effectiveness of these strategies

Empty text area for strategies previously trialled to reduce or prevent seclusion or mechanical restraint.

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13. Plan for reducing use of restrictive practices

- Detail actions to mitigate risks and strategies to improve the behaviours of concern or reduce the frequency and duration of the use of seclusion or mechanical restraint. For example:
 - level of observations, frequency of medical reviews
 - use of sensory items to reduce distress / agitation
 - allowance of personal items for comfort / reassurance
 - activities to divert attention / reduce boredom
 - contact with trusted member of treating team / peer worker / carer / family
 - medication, nicotine replacement therapy, other therapy
 - positive behaviour support strategies.

Strategies and interventions	Intended outcome	Target date

DO NOT WRITE IN THIS BINDING MARGIN

14. Directions / Limitations

Has the Chief Psychiatrist given directions about the use of seclusion or mechanical restraint that apply to this patient? Yes No

If yes, specify what action has been taken to satisfy the Chief Psychiatrist's directions:

Has the treating consultant psychiatrist or clinical director specified limitations to the use of seclusion or mechanical restraint that apply to this patient? Yes No

If yes, specify what action has been taken to satisfy these limitations:



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Are limitations placed on the number of hours in a 24 hour period during which the patient may be held in seclusion or mechanical restraint under this plan? Yes No

If yes, specify limitations:

15. Consumer involvement

Was the consumer and / or support person involved in developing this plan? Yes No

If no, has the plan been explained to the consumer and / or support person? Yes No

16. Authorised doctor's details

Name:		Designation:	
Signature:	Date:	Time (24hr):	Contact number:

17. Clinical Director approval

• Chief Psychiatrist approval is required for all mechanical restraint use.

Approved Not approved

Conditions of approval or reasons not approved:

Name:		Designation:	
Signature:	Date:	Time (24hr):	Contact number:

Is Chief Psychiatrist approval required? Yes No

Refer to the Chief Psychiatrist guidelines for seclusion and mechanical restraint.

18. Chief Psychiatrist approval

Approved Not approved

Conditions of approval or reasons not approved:

Print name:	Signature:	Date:
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DO NOT WRITE IN THIS BINDING MARGIN