CHAPTER 13 – SAFETY AND SECURITY IN AUTHOURISED MENTAL HEALTH SERVICES

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1. Introduction

The *Mental Health Act 2000* (the Act) establishes requirements for interventions to prevent risk of harm, and contains provisions relating to the search of patients and their possessions within an authorised mental health service. The Act also allows the administrator to refuse entry to a visitor in certain circumstances. These interventions and provisions are intended to ensure a safe and therapeutic environment for all patients receiving treatment or care within the service.

Additional provisions apply to high security units. In particular, the Act sets out processes for conducting a search on a visitor to a high security unit and processes relating to mail and items received for patients in a high security unit.

The provisions of the Act summarised below can be read in full in the *Mental Health Act 2000*, Chapter 4A (Restraint and seclusion of patients) and Chapter 10 (Security of authorised mental health services).

1.1 Director of Mental Health resources

Director of Mental Health resources of particular relevance to this chapter include:

- **Appendix 3 - Forensic patient management policy and procedures**
- **Appendix 4 - Policy and practice guidelines for the care of disability forensic patients**

1.2 Other resources of relevance to this chapter

Other resources of relevance to this chapter include:

- **Policy statement on reducing and where possible eliminating restraint and seclusion in Queensland mental health services**
- **Guidelines - Searches in authorised mental health services**
1.3 Legislative principles

Legislative principles for exercising powers and performing functions must be applied (s8-9)

While the legislative principles apply to all decisions made under the Act, they are of particular significance to very restrictive practices such as mechanical restraint and seclusion.

In authorising mechanical restraint and seclusion, the doctor or the senior registered nurse should be guided by the Act’s principles in s9. In particular:

- any power or function exercised under the Act must be exercised so that a person’s liberty and rights are affected only if there is no less restrictive way to protect the person’s health and safety or to protect others; and
- if the person’s liberty or rights are to be affected, the effect is to be the minimum necessary in the circumstances.

General principles underlying the use of mechanical restraint or seclusion

The use of mechanical restraint and seclusion is guided by the following principles:

- The safety and wellbeing of the patient, staff and others is of paramount importance in managing risk of serious imminent harm;
- Mechanical restraint or seclusion may be appropriate only when all other safe alternative options have been considered and trialled;
- Mechanical restraint or seclusion is used for the minimum period of time required to allow the patient to safely regain control of their behavior;
- All actions undertaken by staff are justifiable and proportional to the patient’s behavior;
- The patient is closely reviewed and monitored according to specific requirements so that any deterioration in their physical condition is noted and managed promptly and appropriately.

2. Mechanical restraint (s162A-I)

The Act establishes requirements for the use of mechanical restraint in an authorised mental health service. It is an offence to apply mechanical restraint to a person in an authorised mental health service other than in accordance with the Act.
This section sets out legislative requirements pertaining to restraint. These requirements should be considered in the context of the Policy statement on the reduction and where possible elimination of restraint and seclusion in Queensland Mental Health Services.

Restraint is known to cause harm including psychological distress, physical injury and in some instances death. Reducing the use of, and where possible eliminating restraint is one of four priorities in the National safety priorities in mental health: a national plan for reducing harm.

2.1 Definition of mechanical restraint

The Act defines mechanical restraint as:

‘the restraint of a person by the use of a mechanical appliance, approved under section 162B, preventing the free movement of the person’s body or a limb of the person’.

However, the use of a surgical or medical appliance for the proper treatment of physical disease or injury is not considered a mechanical restraint.

2.2 Approved mechanical appliances

Under s162B of the Act, the Director of Mental Health (the Director) must approve the mechanical appliances that may be used for mechanical restraint of a person.

The Director has restricted the use of mechanical restraint to:

<table>
<thead>
<tr>
<th>Appliance</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrist cuffs to waist belt</td>
<td>A band fastened around the waist linking to bands fastened around the wrists</td>
</tr>
</tbody>
</table>

If the Clinical Director considers that an alternative mechanical appliance needs to be applied to prevent injury to a patient or someone else, the Clinical Director should immediately contact the Director. The Director will determine whether the alternative mechanical appliance is approved, having regard to the individual circumstances of the case.

Any such approval will only apply to that individual for the period specified by the Director.
2.3 Authorisation of mechanical restraint

Mechanical restraint may be authorised by a doctor for an involuntary patient in an authorised mental health service, only if the doctor ‘is satisfied it is the most clinically appropriate way of preventing injury to the patient or someone else’. Mechanical restraint will only be used when all other less restrictive options for managing the patient’s behaviour and level of risk have proved unsuccessful.

Mechanical restraint can only be authorised for an involuntary patient. This includes:

- a patient detained for assessment;
- a patient subject to an involuntary treatment order;
- a classified patient; and
- a patient subject to a forensic order or a disability forensic order.

The doctor’s authorisation is given by completing the authorisation of mechanical restraint and notification to Director of Mental Health form (authorisation form). The maximum period for a doctor’s authorisation is three (3) hours. The doctor must record:

- the type of restraint authorised;
- the reasons for the restraint;
- any restrictions on the circumstances in which the restraint may be applied;
- the maximum period or periods for which the restraint may be applied;
- the intervals at which the patient must be observed while in restraints;
- any special measures necessary to ensure the patient’s proper treatment or care while in restraints; and
- the time (not longer than three (3) hours after the authorisation is given) when the authorisation ends.

The doctor’s authorisation is for one episode of restraint within the maximum three (3) hour timeframe. If a patient is released, a new authorisation for mechanical restraint is required.

The Act requires that the doctor’s authorisation be recorded in the patient’s clinical file. The authorisation form should be inserted chronologically in the clinical notes. Alternatively, the doctor may make an entry in the clinical notes that mechanical restraint has been authorised and identify the section of the file where the authorisation form can be located.
2.4 Requirements when mechanical restraint is authorised

A doctor or senior registered nurse on duty may, with the help, and using the minimum force that is necessary and reasonable in the circumstances, apply the restraint as authorised to the patient.

If a doctor authorises mechanical restraint, the senior registered nurse on duty must:

♦ ensure that the restraint is applied as authorised by the doctor;
♦ ensure the patient’s biological needs are met, including for example, being given sufficient bedding and clothing, sufficient food and drink and access to toilet facilities; and
♦ make a record in the patient’s clinical file of:
  o the type of restraint applied;
  o if the doctor has stated any restrictions on the application of the restraint – the circumstances in which the restraint was applied;
  o the time the restraint was applied;
  o the person who applied the restraint; and
  o the time the restraint was removed.

The Director may order removal of the restraint from a patient in an authorised mental health service at any time. If the senior registered nurse on duty is satisfied the patient can be safely treated or cared for without the restraint or the Director orders the removal of restraint, the nurse must immediately direct the removal of the restraint.

A record of observations during the period of restraint should be retained in accordance with the usual practice at the health service facility.

2.5 Reporting requirements

The administrator must give the Director written notice about the mechanical restraint of a patient in the health service as soon as practicable after the mechanical restraint is applied to the patient.

3. Seclusion (s162J-W)

The Act establishes requirements for the use of seclusion in an authorised mental health service. It is an offence to seclude a person in an authorised mental health service other than in accordance with the Act.
This section sets out legislative requirements pertaining to seclusion. These requirements should be considered in the context of the *Policy statement on the reduction and where possible elimination of restraint and seclusion in Queensland Mental Health Services.*

In line with the *National safety priorities in mental health: a national plan for reducing harm*, this section identifies principles and strategies for reducing and, where possible, eliminating the use of seclusion in mental health services.

### 3.1 Definition of seclusion

The Act defines seclusion of a patient as:

> ‘confinement of the patient at any time of the day or night alone in a room or area from which free exit is prevented’.

However, the Act specifically excludes a patient’s ‘overnight confinement for security purposes’ from the definition of seclusion.

Overnight confinement for security purposes only applies to:

- a high security unit; or
- another mental health service prescribed by regulation for this purpose.

### 3.2 Authorisation of seclusion

**Patient must be an involuntary patient**

The use of seclusion in an authorised mental health service can only be authorised for an involuntary patient in an inpatient facility of an authorised mental health service. An involuntary patient includes:

- a patient detained for assessment;
- a patient subject to an *involuntary treatment order*;
- a classified patient; or
- a patient subject to a *forensic order* or a *disability forensic order*.

Note: For the purposes of authorising seclusion, an emergency department is considered to be part of the inpatient facility of an authorised mental health service (see chapter 2, section 2.2 of the Resource Guide).

**Seclusion must be authorised by a doctor or senior registered nurse**

Seclusion must be authorised by a doctor or, in urgent circumstances, by the senior registered nurse on duty.
The doctor or nurse must be reasonably satisfied that:

- the seclusion is necessary to protect the patient or other persons from imminent physical harm, and
- there is no less restrictive way of ensuring the safety of the patient or other persons.

Seclusion is to be used to manage disturbed or violent behaviour, and must only be authorised when all other less restrictive options for managing the patient’s behaviour and level of risk have proved unsuccessful.

Seclusion will not be used:

- when the patient is actively self-harming;
- as a routine procedure when a patient is abusive, threatening or destructive of property;
- as a routine procedure following physical restraint;
- as a low stimulus environment – other options will be trialed first;
- to prevent a patient from absconding from a mental health unit;
- as a punishment or threat.

### 3.3 Seclusion authorised by a senior registered nurse

In urgent circumstances, seclusion may be authorised by the senior registered nurse on duty.

In authorising seclusion, the senior registered nurse must complete a *seclusion authorised by a senior registered nurse* form.

The senior registered nurse must immediately tell a doctor of the seclusion and record the following details in the patient’s clinical file:

- the reasons for the seclusion;
- the time the patient was placed in seclusion; and
- the time the nurse told a doctor of the seclusion.

If a senior registered nurse authorises seclusion, a doctor must examine the patient as soon as practicable. In making the examination the doctor must:

- record the examination and time of examination in the patient’s clinical file; and
order the patient’s release from seclusion or authorise the patient’s seclusion by making a seclusion order (see section 3.4 in this chapter).

If the patient is released from seclusion prior to the doctor reviewing the patient, the patient must still be reviewed by a doctor and the details of the examination recorded in the clinical file.

The seclusion authorised by a senior registered nurse form should be inserted chronologically in the clinical notes section of the patient’s clinical file. Alternatively, the nurse may make an entry of the seclusion in the clinical notes and identify the section of the file where the form can be located.

3.4 Seclusion authorised by a doctor

To authorise seclusion for a patient the doctor must make a seclusion order. The doctor’s order may:

- state the reasons for the seclusion;
- state the time the order is made and the time it ends – the total duration of which must not exceed three (3) hours;
- indicate whether the senior registered nurse on duty is authorised to release the patient from, or return the patient to, seclusion during the period of the order; and
- specify any measures necessary to ensure the patient’s proper treatment or care while secluded.

The Act also empowers the doctor to determine that it is not clinically necessary to continuously observe the patient while in seclusion, and to specify observation intervals of not longer than 15 minutes.

Less frequent observation must be clinically justified and the reasoning clearly documented in the patient’s clinical file.

While the Act enables a doctor to specify that it is not clinically necessary to continuously observe the patient while secluded, a best practice approach is that this determination is made by an authorised psychiatrist, on the basis of a comprehensive risk assessment.

In any case, the clinical assessment and decision about observation requirements should have particular regard to vulnerable patient groups, for example members of Aboriginal and Torres Strait Islander communities, victims of torture and trauma, children and young people and people from culturally and linguistically diverse backgrounds who may be high risk for trauma, suicide or self-harm if placed in seclusion.
A doctor’s order for seclusion must be based on a face to face examination and cannot be made in advance (i.e. in anticipation that seclusion may be required). Advance authorisation of seclusion is inconsistent with the requirement for the doctor to be satisfied there is a risk of ‘imminent physical harm’.

The *seclusion order* form should be inserted chronologically in the clinical notes section of the patient’s clinical file. Alternatively, the doctor may make an entry about the *seclusion order* in the clinical notes and identify the section of the file where the form can be located.

### 3.5 Requirements relating to patients in seclusion

**Biological and support needs**

The senior registered nurse on duty must ensure the patient’s biological needs are met while in seclusion including, for example, ensuring that the patient is provided with:

- sufficient bedding and clothing;
- sufficient food and drink; and
- access to toilet facilities.

It is good practice to document how and when the patient’s biological needs were met during seclusion.

Consideration should also be given to the cultural needs of the patient, and where necessary, timely access provided to an appropriate support person or cultural adviser.

**Observation during seclusion**

If seclusion is authorised by the senior registered nurse on duty, the nurse must ensure the patient is *continuously* observed while in seclusion.

If seclusion is authorised by a doctor, the senior registered nurse on duty must ensure that the patient is continuously observed unless the order made by the doctor states that this is not clinically necessary. In this instance, the patient must be observed at intervals (not longer than 15 minutes) stated on the order.

A record of observations during the period of seclusion should be retained in accordance with the usual practice at the health service facility.
Release from seclusion

If the senior registered nurse has been authorised by the doctor to release the patient from or return the patient to seclusion, the nurse may:

- release the patient from seclusion if the nurse is satisfied that seclusion is no longer necessary; or
- return the patient to seclusion if the doctor’s order is still in force and the nurse is satisfied that seclusion is necessary to protect the patient or others from imminent harm and there is no less restrictive way of ensuring the patient’s safety or that of others.

Release from seclusion occurs when the senior registered nurse makes a clinical determination that the patient no longer requires seclusion. It does not include leaving the seclusion room to meet the patient’s biological needs; for example, to access toilet facilities.

Immediately after releasing the patient from or returning the patient to seclusion, the nurse must record in the patient’s clinical file:

- the time of the release from or return to seclusion; and
- the reasons for the release or return.

The details of the patient’s release from and return to seclusion must also be recorded on the seclusion order and in the information system.

The Director may order a patient’s release from seclusion at any time. A doctor or senior registered nurse on duty must immediately release the patient from seclusion on the order of the Director.

The administrator must ensure that appropriate procedures are in place to ensure the information system is updated to reflect the details of the seclusion order, and any release from or return to seclusion.

3.6 Monitoring and reporting requirements

The administrator is responsible for monitoring the use of seclusion as part of the service quality improvement activities.

The Act requires the administrator to notify the Director as soon as practicable after a patient has been secluded. In practice, this notification is made by:

- entering the details of the seclusion into the Consumer Integrated Mental Health Application (CIMHA); and
- giving written notice to the Director in specified circumstances, as outlined below and in section 4 of this chapter.
A copy of the seclusion authorised by a senior registered nurse and/or seclusion order must be provided to the administrator without delay. All relevant details are to be entered in CIMHA on the same or next business day.

Written notice to the Director is given by way of a third authorisation of seclusion in 24 hours form. A 24 hour period commences at 00:00 hours and ends at 23:59 hours on any calendar day. The doctor or senior registered nurse on duty must give written notice to the Director as soon as practicable after the third authorisation of seclusion within a 24 hour period. This applies regardless of the duration of the seclusion, and includes authorisations by the senior registered nurse.

4. Seclusion and/or mechanical restraint in high security unit

Special arrangements apply to patients for whom the Director has authorised an individual management plan for the minimisation of seclusion and/or mechanical restraint use (seclusion/restraint use minimisation plan).

To apply to have a plan approved, a proposed seclusion/restraint use minimisation plan and clinical report must be submitted to the Director addressing current presentation, psychiatric history, risk assessment, and management strategies employed to date.

The Office of the Chief Psychiatrist will review the clinical report and seclusion/restraint use minimisation plan and make a recommendation on whether the seclusion/restraint use minimisation plan should be approved by the Director.

The Clinical Director of the high security unit will be advised of the Director’s decision in writing as soon as possible, but within one week of receiving the submission.

The Clinical Director of the high security unit must provide the Director with a weekly update on the seclusion/restraint use minimisation plan which sets out:

- a summary of the patient’s progress under the seclusion/restraint use minimisation plan during the preceding week; and
- a proposed management plan for the forthcoming week, including frequency and duration of seclusion and mechanical restraint.

Any significant amendments to the seclusion/restraint use minimisation plan will require approval by the Director.
A comprehensive review of the seclusion/restraint use minimisation plan involving the Clinical Director for the high security unit, treating psychiatrist, Director and/or the Office of the Chief Psychiatrist will be conducted on a three (3) monthly basis, or earlier if required.

Notification of a third authorisation of seclusion in 24 hours for patients on a seclusion/restraint use minimisation plan is not required in the high security unit, unless there is a departure from the plan.

5. Search of patients and their possessions (s353-360)

The Act authorises the search of a patient and their possessions without the patient’s consent in the following circumstances:

♦ a doctor or the senior registered nurse on duty may authorise the search of a patient if the doctor or nurse reasonably believes the patient has possession of a harmful thing; and

♦ a patient may be searched (i.e. without an authorisation by a doctor or nurse) on admission or entry to a high security unit.

For the purpose of the search provisions, a patient is defined to include any person admitted to; or assessed, examined, detained or treated for a mental illness; and/or provided with care for an intellectual or cognitive disability in an authorised mental health service.

The provisions therefore apply to voluntary and involuntary patients.

5.1 Search authorised by doctor or senior registered nurse (s353, 354, 541A)

Obtaining patient consent as far as possible

In line with the Act’s principles, a search of a patient or their possessions should, as far as possible, occur with the patient’s consent. Non-consensual searches (in particular, search of a person) represent a significant personal intrusion. The authority provided in the Act should only be considered if it is not possible to obtain consent and the individual circumstances warrant a non-consensual search.

In seeking consent, the patient should be provided a full explanation of why the search is being requested and what it entails. The health practitioner should be satisfied that the patient understands the explanation.
Under section 541A of the Act, the authorised doctor must tell or explain something to a patient:

- in a way that the patient is most likely to understand; and
- in a way that has appropriate regard to the patient’s age, culture, mental illness, communication ability and any disability.

If the authorised doctor believes that the patient has not understood what they were told or explained, they must record details of the fact in the patient's file.

**Authorisation by doctor or the senior registered nurse on duty**

In circumstances where it is not possible to obtain the patient’s consent, a doctor or the senior registered nurse on duty may authorise a search if the doctor or nurse ‘reasonably believes’ the patient has possession of a ‘harmful thing’.

‘Reasonably believes’ is defined to mean ‘believes on grounds that are reasonable in the circumstances’.

‘Harmful thing’ is defined to mean anything:

- that may be used to
  - threaten the security or good order of an authorised mental health service; or
  - threaten a person’s health or safety, and
- that, if used by a patient in an authorised mental health service, is likely to adversely affect the patient’s treatment or care.

Examples provided in the Act include a gun or replica, a dangerous drug, alcohol and medication.

In considering the need to authorise a search, the doctor or senior registered nurse on duty should have regard to the individual circumstances of the case. Relevant factors will vary with individual circumstances but may include, for example:

- the reasons for the patient’s objection;
- the patient’s history;
- any collateral information; and
- the environment, including items that might constitute a harmful thing in that environment.

The doctor or senior registered nurse on duty should document their decision and the reasons for their decision in the patient’s file, including the factors that were taken into account.
Search may be conducted by doctor, nurse, or another health practitioner

Before carrying out the search, the doctor or nurse must first tell the patient the reasons for the search and how it is to be carried out.

The doctor or nurse may conduct the search, or may authorise another health practitioner to conduct the search.

As identified in chapter 2 of the Resource Guide, a ‘health practitioner’ may include persons appointed by the administrator (under section 505A of the Act).

When considering the appointment of a person as a health practitioner for the purpose of the search provisions (for example, an enrolled nurse), the administrator should take account of:

- the type of searches that are to be conducted (i.e. different skills may be required depending on whether it is intended the person be permitted to conduct a search of belongings or a search of the person);
- the person’s experience and expertise in mental health service provision and the level of supervision required (for example, in some circumstances, it may be appropriate to require the presence of a registered nurse); and
- the type/level of training that the person has undertaken or requires to conduct searches.

In making an appointment under section 505A, an administrator should limit the person’s powers as a health practitioner as appropriate in the circumstances (for example, the written instrument of appointment may specify that the person is authorised to conduct a search of belongings only and/or may require that the person only conduct a search under the supervision of a registered nurse).

5.2 Search on entry to a high security unit (s355)

When a patient is admitted to or enters a high security unit, an ‘authorised officer’ may search the patient or the patient’s possessions to detect harmful items.

Before carrying out the search, the officer must tell the patient the reasons for the search and how it is to be carried out.

An ‘authorised officer’ for a high security unit includes a health practitioner providing mental health services at the unit or a security officer for the unit. Authorised officers must have identity cards
approved by the administrator for the high security unit. The identity card must contain a recent photograph of the officer and identify the person as a health practitioner (including occupation) or security officer at the unit.

5.3 Requirements for conducting a search (s356-360)

Search of patient's possessions

When undertaking a search of the patient's possessions, the person conducting the search must give the patient an opportunity to be present.

The person conducting the search may:

- pass a hand-held electronic scanning device over or around the patient's possessions;
- open or inspect an item in the patient's possession; and/or
- remove and inspect any detected item.

The search must be carried out in a way that respects the patient's dignity to the greatest possible extent and causes as little inconvenience as is practicable in the circumstances.

Search of patient

A search of the patient must be conducted:

- by a person who is the same gender as the patient; and
- in a part of a building that ensures the patient's privacy.

The person conducting the search may do one or more of the following:

- pass a hand-held electronic scanning device over or around the patient;
- remove and inspect an outer garment or footwear of the patient;
- remove and inspect all items from the pockets of the patient's clothing;
- touch the clothing worn by the patient to the extent reasonably necessary to detect items in the patient's possession; and/or
- remove and inspect any detected item.

Also, the person conducting the search may, with the approval of the administrator, remove and inspect all, or part of, the patient's outer clothing and anything found in the clothing. The administrator can only
give approval if reasonably satisfied it is necessary for carrying out an appropriate search.

The search must be carried out in a way that respects the patient's dignity to the greatest possible extent and causes as little inconvenience as is practicable in the circumstances.

The person conducting the search may carry out the search with the help and using the minimum force that is necessary and reasonable in the circumstances.

**Seizing harmful items found during a search**

The person conducting the search may seize anything found during a search that the person reasonably suspects is a harmful thing.

If the administrator believes the item is connected with or is evidence of the commission (or intended commission) of an offence against an Act, the administrator may seize the item and give it to an appropriate person under the relevant Act.

If the administrator is reasonably satisfied the seized item is harmful, but not illegal the administrator must:

- keep it for the patient and give it to the patient on the patient’s release from the health service;
- with the patient’s agreement, give it to someone else;
- if the administrator is satisfied someone else is entitled to possession of the item, give or send it to the person; or
- if the administrator is reasonably satisfied it is of negligible value, dispose of it in the way the administrator considers appropriate.

**Record of conducting a search**

The person conducting the search (whether a search of the patient’s possessions or the patient) must make a record of specified information if:

- the search is authorised by a doctor or health practitioner;
- the administrator gave approval for the person conducting the search to remove and inspect clothing other than an outer garment; and
- the person conducting the search seizes any item as a result of the search.
The person conducting the search must make a record of the following matters immediately following the search:

- the reasons for the search;
- if the search was authorised by a doctor or senior registered nurse on duty - the name of the doctor or nurse;
- the name of the person conducting the search;
- how the search was carried out;
- the results of the search; and
- anything seized as a result of the search.

In addition, the administrator must make a written record of the administrator’s decision in relation to any item seized in the search.

**Compensation s373**

A patient may claim from the State the cost of repairing or replacing possessions damaged in the exercise of a power under the search provisions.

The cost may be claimed and ordered in a proceeding:

- brought in a Court of competent jurisdiction for the recovery of the amount claimed; or
- for an offence against the Act brought against the patient.

A Court may order an amount be paid only if it is satisfied it is just to make the order in the circumstances of the particular case.

6. **Search of visitors to a high security unit (s361-371)**

Provisions relating to search of visitors or a visitor’s possessions only apply in a high security unit.

6.1 **Authority to request search and refuse entry (s361, 362)**

An authorised officer for a high security unit (see section 5.2 of this chapter) may ask a visitor to submit, or submit their possessions to a search.

The officer must provide the visitor with an explanation in general terms of:

- the officer’s powers in relation to the search;
how the search is to be carried out; and
the visitor’s rights under these provisions.

If the visitor does not agree to the request, the authorised officer may refuse the visitor permission to enter the high security unit or, if the visitor is in the unit, direct the visitor to immediately leave the unit.

Penalties apply if the visitor does not comply with the direction to leave the unit.

6.2 Conducting search of visitor and visitor’s possessions (s363-373)

Authority and requirements for authorised officer conducting search

In conducting the search, the authorised officer may ask the visitor to do any of the following:

- walk through an electronic scanning device;
- remove a stated outer garment or footwear;
- remove everything from the pockets of the visitor’s clothing; and/or
- open or inspect anything in the visitor’s possession.

The officer is authorised to:

- pass a hand-held electronic scanning device over or around the visitor or the visitor’s possessions;
- inspect an outer garment or footwear removed by the visitor;
- touch the clothing worn by the visitor to the extent reasonably necessary to detect items in the visitor’s possession; and
- remove and inspect any detected item.

However, in exercising their authority, the officer conducting the search must:

- when conducting a search of the visitor’s possessions - ensure the visitor is present or has been given the opportunity to be present;
- when conducting a search which involves touching the visitor’s clothing and/or removing an item for inspection
  - only conduct the search if the visitor is the same sex as the officer; and
  - conduct the search in a part of a building that ensures the visitor’s privacy;
ensure that any search is conducted in a way that respects the visitor’s dignity to the greatest possible extent and causes as little inconvenience to the visitor as is practicable in the circumstances; and

- stop the search if the visitor does not want the search to continue and is prepared to leave the high security unit immediately.

The Act provides a penalty if the visitor has requested that the search be stopped and does not leave the unit immediately.

**Items left with the authorised officer during visit**

If an item is reasonably suspected of being harmful an authorised officer may ask the visitor to leave the item with them until the visitor leaves the high security unit.

If the visitor refuses to comply, the authorised officer may refuse the visitor permission to enter the unit or, if the visitor is in the unit, direct them to immediately leave the unit. Penalties apply if the visitor does not comply with the direction to leave the unit.

In addition, if the visitor does not want the authorised officer to inspect anything in their possession (for example, the contents of a handbag), they may choose to leave the item with the officer until they leave the high security unit.

If the visitor has left an item with an authorised officer, the officer must ensure the item is returned when the visitor is leaving the high security unit.

**Seizing harmful items found during a search**

The authorised officer may seize a harmful item found during the search if the officer reasonably believes it is connected with or is evidence of the commission or intended commission of an offence.

The authorised officer must give a receipt for the item to the visitor from whom it was seized. The receipt must describe generally the item seized and its condition.

If the administrator reasonably believes the seized item is connected with or is evidence of the commission or intended commission of an offence against an Act, the administrator must give it to an appropriate person under the relevant Act.

If the administrator is not reasonably satisfied the item is evidence of the commission or intended commission of the offence, the
administrator must ensure reasonable efforts are made to return the item to the visitor.

Forfeiture of seized items

A seized item is forfeited to the State if the administrator can not find the visitor from whom it was seized, or can not return it after making reasonable efforts.

However, this does not require the administrator to make inquiries if it would be unreasonable in the particular circumstances to make inquiries to find the visitor and return the item.

In making these decisions, regard must be had to an item’s nature, condition and value in deciding whether it is reasonable to make inquiries or efforts and what inquiries or efforts, including the period over which they are made, are reasonable.

Access to seized items

Until a seized thing is forfeited or returned, the administrator must allow its owner to inspect it and, if it is a document, to copy it unless it would be impracticable or unreasonable to allow the inspection or copying.

Compensation s373

A visitor may claim from the State the cost of repairing or replacing possessions damaged in the exercise of a power under the search provisions.

The cost may be claimed and ordered in a proceeding:

- brought in a Court of competent jurisdiction for the recovery of the amount claimed; or
- for an offence against the Act brought against the visitor.

A Court may order an amount be paid only if it is satisfied it is just to make the order in the circumstances of the particular case.

7. Postal articles and other items sent or received by patients in high security units

The Act makes it an offence to interfere with postal items for patients other than in accordance with the requirements set out in the Act.

These provisions only apply in high security units. Patients not detained in a high security unit have the same rights as any other person in the community to send and receive postal items.
7.1 Postal articles sent by patients in a high security unit (s349)

The addressee of a postal article sent from a patient of a high security unit may ask the administrator to withhold mail from the patient to the addressee.

These provisions do not apply to the patient’s correspondence to:

- a member of the Parliament of the Commonwealth or a State;
- the Mental Health Court;
- the Mental Health Review Tribunal (the Tribunal);
- the Director;
- a community visitor under the Guardianship and Administration Act 2000;
- the Health Quality and Complaints Commission under the Health Quality and Complaints Commission Act 2006;
- the ombudsman appointed under the Ombudsman Act 2001; and
- another person prescribed under a regulation.

7.2 Items received for patients in high security units (s350)

The administrator of a high security unit may open or examine anything received at the high security unit for a patient. However, before opening or examining an item received for the patient, the administrator must tell the patient so that the patient may ask their lawyer to be present at the opening or examination.

The administrator may only open and examine the item in the patient’s presence and, if the patient requests, the presence of their lawyer. However the administrator may decide it is not reasonably practicable to wait for the patient’s lawyer.

If, on opening and examining the item, the administrator is satisfied the item is a danger to the patient or someone else or to the security of the unit, the administrator can:

- with the patient’s agreement, give it to someone else;
- keep it for the patient and give it to the patient on the patient’s release from the unit;
- return it to the sender; or
- if the administrator is reasonably satisfied it is of negligible value, dispose of it in the way the administrator considers appropriate.
If the administrator believes the item is connected with or is evidence of the commission or intended commission of an offence, the administrator can seize the item and give it to an appropriate person under the relevant Act.

The administrator must make a written record in the patient’s file of the administrator’s decision in relation to the item seized.

8. **Exclusion of visitors**

Provisions relating to exclusion of visitors apply to all authorised mental health services (i.e. it is not limited to high security units).

8.1 **Determination by administrator (s374)**

The administrator may refuse to allow a person to visit a patient in the health service if satisfied the proposed visit will adversely affect the patient’s treatment or care.

The administrator may, for example, be satisfied a patient’s treatment or care will be adversely affected if on a previous visit by a person, the patient’s mental state deteriorated.

The administrator must give the person written notice of the decision *(notice of refusal to allow a person to visit a patient)* stating the following:

- the reasons for the decision to refuse to allow the person to visit the patient;
- that the person may appeal to the Tribunal against the decision within 28 days after the person receives the notice; and
- how an appeal is made.

8.2 **Appeals against decision of administrator (s375-379)**

If the person *who is* refused entry is dissatisfied with this decision, the *person* may appeal against the decision to the Tribunal.

The person must give the notice of appeal to the Tribunal within 28 days of receiving the decision of the administrator (i.e. *notice of refusal to allow a person to visit a patient*). However, the Tribunal may extend the time for giving the notice of appeal.

The Tribunal must give notice of the appeal to the administrator within seven (7) days after the appeal is started and seven (7) days’ notice of the hearing to the parties to the appeal. The hearing notice must include
the time and place of the hearing of the appeal, the nature of the hearing and the parties’ rights to be represented at the hearing.

In deciding an appeal, the Tribunal may confirm or revoke the decision appealed against and must give a copy of the decision to the parties to the appeal (i.e. the administrator and the person who was refused visitation to the patient).