Seclusion

1. Purpose

This Policy outlines the relevant provisions of the Mental Health Act 2016, and the Chief Psychiatrist Policy, regarding the seclusion of involuntary patients.

In line with national approaches, this Policy supports the reduction and elimination of seclusion for patients. Seclusion is to be used 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 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.

2. Scope

This Policy is mandatory for all authorised mental health services (AMHS). 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.

This Policy must be implemented in a way that is consistent with the Objects and Principles of the Act.

3. Authorising Legislation

Section 273 of the Mental Health Act 2016.

4. Background

Seclusion of patients in an AMHS is outlined in Chapter 8, part 3 of the Act.

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. Any confinement that meets this definition is regarded as seclusion, including:
- when the patient is not aware of the seclusion, and
- when the person requests or agrees to the seclusion.

The duration of seclusion is not relevant in determining what is defined as seclusion. The structure and the dimensions of the area are not relevant in determining what is defined as seclusion. The area may be an open area, for example, a courtyard.

Seclusion does not include the confinement of a person in a high security unit, or another AMHS approved by the Chief Psychiatrist, for a period approved by the administrator of the service of not more than 10 hours between 8.00pm and 8.00am for security purposes. Confinement that is authorised under a law other than the Mental Health Act 2016 is not seclusion.
The decision to use seclusion is a last resort to prevent imminent and serious harm to the patient or another person, and only after less restrictive strategies have been trialled or appropriately considered and excluded. Seclusion can only be used if there is no other reasonably practicable way to protect the patient or others from physical harm.

The use of seclusion can cause significant and lasting distress and injury to both patients and staff and has been identified as a contributing factor in patient deaths. The potential harmful effects of seclusion must be balanced against the risk of harm of the behaviour in question. Services must adopt evidence-based and best practice approaches to safely reduce and, where possible, eliminate the use of seclusion.

Under the Act, seclusion may only be used on an involuntary patient in an AMHS who is subject to a treatment authority, forensic order or treatment support order, or a person absent without permission from another State who is detained in an AMHS.

Seclusion cannot be authorised under an advance health directive, or with the consent of a guardian, attorney or, if the person is a minor, the minor’s parents.

Seclusion may be authorised by an authorised doctor for up to 3 hours.

Seclusion may occur for no more than 9 hours in a 24-hour period, but may be extended beyond this time if it is approved under a reduction and elimination plan.

In addition, an extension of an additional 12 hours may be authorised for a patient to allow a reduction and elimination plan to be prepared. This must be approved by a clinical director. An extension of seclusion may only be granted once for each period of the admission in which the patient requires acute management. Acute management is determined based on clinical considerations. The Chief Psychiatrist Practice Guidelines for Seclusion provides examples to assist with this determination. 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 an extension of seclusion may be granted. The authorised doctor must notify the Chief Psychiatrist when an extension has been approved.

In an emergency, a health practitioner in charge of an inpatient or other unit within an AMHS may seclude a person for up to 1 hour. The health practitioner must, as soon as practicable, tell an authorised doctor of the seclusion. Emergency seclusion may be authorised for no more than 3 hours in a 24-hour period.

A patient in seclusion must be continuously observed, or observed at intervals of no more than 15 minutes. (See section 5 of this Policy, which requires Aboriginal and Torres Strait Islander people to be continuously observed during seclusion).

An authorised doctor must remove a person from seclusion if it is no longer necessary to protect the person or others from physical harm.

The health practitioner in charge of the unit must also do this if the initial authorisation by the authorised doctor allows it. A health practitioner, other than the health practitioner in charge of the unit, may also remove the patient from seclusion if it is no longer necessary, provided the authorised doctor has stated this may occur in the initial authorisation. A health practitioner who removes a patient from seclusion must, as soon as practicable, tell the authorised doctor of the removal.

The Chief Psychiatrist may direct the removal of a person from seclusion.
The Chief Psychiatrist has the power to issue directions about the use of seclusion. This could apply to an individual patient, a class of patients, or all patients in an AMHS. A direction could require the use of reduction and elimination plans.

5. Policy

Seclusion must occur in a room or area:
- with adequate space and lighting
- where staff have clear visibility of the patient
- which is free from hazards such as hanging points, objects which may be used to inflict harm, or wet floors, and
- where staff can have easy access to the room, particularly to administer urgent medical treatment.

If seclusion is authorised under the Act, staff involved in the seclusion must:
- 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
- use added caution and consider alternative strategies to seclusion for patients who are at significant risk of suicide
- be appropriately trained to protect the welfare, dignity and safety of the patient (for staff using seclusion under the Act, training must include de-escalation strategies, trauma-informed care, recovery-oriented practice and de-briefing strategies)
- 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 released from seclusion
- ensure that no more physical force is used to seclude a patient than is necessary and reasonable in the circumstances
- ensure the patient is in safe clothing and that personal items do not compromise the safety of the patient or staff; staff should also ensure the patient has access to physical aids they normally would use such as glasses, hearing aids or oxygen apparatus if they do not present a risk
- observe for signs of physical or mental distress, and ensure that clinical concerns are appropriately escalated and that appropriate treatment and care is provided
- monitor patients where intramuscular or intravenous medication was administered within one hour prior to the use of seclusion or during the seclusion, and seek immediate medical treatment if there is a concern
- be aware of heightened vulnerability to significant psychological trauma from seclusion, especially for minors, patients with a history of trauma, abuse or detention, or patients of Aboriginal and Torres Strait Islander background
- conduct a review with all staff involved in the seclusion as soon as practicable after the event to evaluate the triggers which resulted in the need to seclude the patient and the methods used to respond to the event
- consider debriefing staff following the seclusion in accordance with local policy and procedures
- conduct a debriefing 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 as soon as clinically appropriate after the event (include support persons such as a family member or peer worker where possible and appropriate), and
- complete all required reports and documentation.

These requirements are in addition to those outlined in section 260(b) of the Act, namely that the patient must be provided with:
- sufficient bedding and clothing
- sufficient food and drink, and
- access to toilet facilities.

Aboriginal and Torres Strait Islander people must be continuously observed while in seclusion.
Seclusion must not be used:
• as a substitute for other less restrictive interventions
• as a form of discipline or punishment
• as a substitute for adequate staffing levels
• as a substitute for staff training in crisis prevention and intervention to manage aggressive, harmful behaviours, or
• when mechanical restraint is being used simultaneously.

Each authorisation of seclusion by an authorised doctor requires a separate medical review of the patient and written authorisation, even when authorisation immediately follows a previous authorisation. A medical review by an authorised doctor must occur at the end of each seclusion event.

5.1 Reduction and Elimination Plans

A reduction and elimination plan outlines measures to be taken to reduce and eliminate the use of seclusion on a patient and to reduce the potential for trauma and harm. The plan reinforces efforts to proactively reduce the use of seclusion on a patient by ensuring clinical leadership, monitoring, accountability and a focus on safe, less restrictive alternatives to seclusion.

It is recommended practice for a reduction and elimination plan to be in place in all instances where a patient is secluded.

A single reduction and elimination plan may apply to both mechanical restraint and seclusion. However, seclusion and mechanical restraint must not be used simultaneously.

The Chief Psychiatrist may issue a direction that a reduction and elimination plan be used for a patient or patients under section 257 of the Act.

The Chief Psychiatrist may delegate the authority to approve a reduction and elimination plan for seclusion to a senior clinician (for example a clinical director) of the AMHS for the first time in a period of an admission in which the patient requires acute management where a reduction and elimination plan is required to seclude a patient for more than 9 hours in a 24 hour period. The approval of a reduction and elimination plan must be for no longer than 7 days.

Subsequent plans must be approved by the Chief Psychiatrist.

The Plan must include the following details:
• the name and date of birth of the patient
• the name of the AMHS
• any previous use of seclusion on the patient
• any strategies previously used to reduce the use of seclusion of 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 the seclusion, and
• the strategies proposed to reduce and eliminate the use of seclusion.
5.2 Recording

The information to be recorded below is in addition to the information recorded in the authorisation under section 258(2) of the Act.

The following information must be recorded in the patient’s clinical record on the Consumer Integrated Mental Health Application (CIMHA):

- the actual times and duration of each seclusion event, and
- any reduction and elimination plans.

In addition, the following information must be recorded on the patient’s clinical record, wherever possible, on 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 the strategies used to avoid the use of seclusion
- clinically relevant details regarding the patient’s physical and mental health status at the time of the seclusion, including signs of alcohol or drug intoxication and withdrawal
- the patient’s behaviour during the seclusion
- whether physical or mechanical restraint directly preceded a seclusion event
- medications administered up to one hour prior, during and immediately after the seclusion (medication name, dosage, frequency and route of administration)
- any adverse events relating to the seclusion
- food and fluid intake during the seclusion
- level of visual observations undertaken
- the results of all clinical reviews of the patient required by this Policy, including the examinations that took place during and immediately after the seclusion, and
- post-event debriefing of the patient, staff and any other relevant persons.

5.3 Notifications

The Chief Psychiatrist must be notified immediately where seclusion results in, or is associated with:

- the death of a patient during or within 24 hours following seclusion of the patient, or
- significant harm to a patient or other person during seclusion or within 24 hours following seclusion of the patient.

Community visitors under the Public Guardian Act 2014 may request information about the use of seclusion on minors in an AMHS. Staff must provide information as recorded under section 5.2 of this Policy when requested by a community visitor (whether or not it is during or connected with a visit).

5.4 Monitoring and Reporting

Monitoring seclusion rates, the types of events that result in seclusion, effective management strategies and any adverse events is a necessary part of reducing and eliminating seclusion.

De-identified and aggregate data will be publically reported in the Chief Psychiatrist Annual Report in accordance with national standards.

6. Supporting Documents

- Nil

Seclusion
Issued under section 273 of the Mental Health Act 2016

Assoc. Prof John Allan
Chief Psychiatrist, Queensland Health
5 March 2017