

Mental Health Act 2016
Chief Psychiatrist Policy

Overnight confinement for security purposes at high security units

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General

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) that promote the national and state priority of reducing and where possible eliminating seclusion.

This policy sets out requirements for the overnight confinement for security purposes of a patient detained in a high security unit who is subject to an approved [Reduction and Elimination Plan](#) (R&E Plan) under the Act.

All requirements set out in the Act and the [Chief Psychiatrist Policy – Seclusion](#) apply to patients in AMHS including those in a high security unit.

Additional guidelines in relation to the use of overnight confinement apply to patients in a high security unit with an approved R&E Plan in circumstances where seclusion under an approved R&E Plan is being utilised as part of the patient’s ongoing management plan.

Scope

This policy is mandatory for all authorised doctors, authorised mental health practitioners, administrators, or other persons or staff of a high security unit exercising a power or function under the Act.

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

Clinicians should work collaboratively with and in partnership with patients 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. Clinicians should consider the timely involvement of appropriate local supports and provide treatment and care with a recovery-oriented focus.

This policy is to be read in conjunction with the relevant provisions of the Act (Chapter 8) and the [Chief Psychiatrist Policy – Seclusion](#).

Policy

1 Application

A high security unit provides treatment and care to patients with significantly challenging behaviours whose risk of harm to self or others cannot be safely managed in a less secure environment. Some patients may require extended periods of seclusion to ensure their own or others’ safety. Consistent with national priorities, the aim is to minimise the use of seclusion for these individuals while ensuring a safe environment for the patient and others.

All requirements set out in the Act and the [Chief Psychiatrist Policy – Seclusion](#) apply to patients in AMHS including those in a high security unit.

Additional guidelines in relation to the use of overnight confinement apply to patients in a high security unit with an approved R&E Plan in circumstances where seclusion under an approved Plan is being utilised as part of the patient's ongoing management plan.

Key points

The administrator of a high security unit may approve overnight confinement for a period of not more than **ten (10) hours**, between 8pm and 8am, during which a patient may be confined for security purposes.

Overnight confinement for this purpose is not captured within the definition of seclusion.

This additional guideline does not apply to patients of a high security unit who are:

- authorised to be in seclusion to manage an acute risk, or
- subject to an [Extension of Seclusion](#).

2 Reduction and elimination plans

R&E Plans outline measures to be taken to proactively reduce, and where possible, eliminate the use of seclusion. In general, R&E Plans are not required to include information about the use of overnight confinement.

Key points

- Where the use of seclusion and overnight confinement is being utilised as part of the patient's management within a high security setting, this must be reflected in the R&E Plan.
- One of the effects of including overnight confinement within an approved R&E Plan is that during the hours of overnight confinement, there is no legislative requirement for an [Authorisation of Seclusion form](#) and a medical review by an authorised doctor to be undertaken every **three (3) hours**.
- A R&E Plan submitted to the Chief Psychiatrist (or delegate) must therefore outline whether, and how, overnight confinement is being utilised for a patient as part of their management plan.

Information provided in the proposed R&E Plan in relation to the use of overnight confinement **must** be patient-specific.

Examples of information in a R&E Plan may include but are not limited to:

- detailing how seclusion is being utilised as part of an ongoing management strategy to address high and persistent risk, rather than an acute situation
- explaining why **three (3) hourly** reviews are not clinically required during overnight confinement, for example:
 - risks may increase if patient is reviewed overnight
 - risks are decreased overnight due to less activity on the ward as other patients are also confined.
- providing strategies to escalate concerns about risks / intervene early in the event that a medical review is required overnight, and
- outlining observation requirements and how these are consistent with the decision not to require 3 hourly medical reviews during overnight confinement (e.g. patient is on constant observations and escalation pathways have been established).

Information provided in relation to overnight confinement **must** address the patient's current presentation, psychiatric history, risk assessment, and management strategies employed to date.

2.1 Approval process for reduction and elimination plans

Key points

Delegation of authority to approve R&E Plans:

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.
- Subsequent plans **must** be approved by the Chief Psychiatrist.

Where a R&E Plan that includes use of overnight confinement is submitted to the Chief Psychiatrist, the process for approval outlined in the [Chief Psychiatrist Policy - Seclusion](#) applies.

- Prior to submitting the R&E Plan to the Chief Psychiatrist, an authorised doctor must have the plan approved by the clinical director.
 - 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 process for seeking urgent approval (e.g. via phone and email) does not apply as the inclusion of overnight confinement may only occur as part of a patient's ongoing management plan.

3 Monitoring and review

As part of the ongoing monitoring and review of the use of seclusion, the authorised doctor completing the [Authorisation of Seclusion form](#) which immediately precedes the commencement of overnight confinement (e.g. the last **Authorisation** prior to 10pm) **must** confirm that the plan outlined in the approved R&E Plan should continue for the patient. If there are any acute changes in the patient's presentation, these should be documented on the [Authorisation of seclusion form](#).

The Clinical Director **must** also review the appropriate use of overnight confinement, at least **weekly**, and updated information must be provided each time a R&E Plan is submitted for approval.

4 Notifications and recording

Key points

The authorised doctor or clinical director of a high security unit **must** enter the R&E Plan into CIMHA for approval.

If the clinical director of a high security unit approves the R&E Plan, the AMHS administrator **must** ensure that the R&E Plan is recorded in CIMHA.

If overnight confinement forms part of a patient's R&E Plan, the AMHS administrator **must** ensure that CIMHA reflects that:

- seclusion is ended for the person at the commencement of the period of overnight confinement (e.g. 10pm), and
- seclusion is authorised for the person at the end of the period of overnight confinement (e.g. 8am).

Issued under section 305 of the *Mental Health Act 2016*

Dr John Reilly
Chief Psychiatrist, Queensland Health
30 April 2020

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 Application – the statewide mental health database which is the designated patient record for the purposes of the Act.
Overnight Confinement	The administrator of a high security unit may approve a period of not more than 10 hours, between 8pm and 8am during which a patient may be confined for security purposes. Overnight confinement for this purpose is not captured within the definition of seclusion.
Reduction and Elimination Plan (R&E Plan)	Outlines measures to be taken to reduce and where possible eliminate the use of seclusion on a patient, and to reduce the potential for trauma and harm as a result of seclusion.
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. It does not include overnight confinement for security purposes in a high security unit or another unit approved by the Chief Psychiatrist for this purpose.

Referenced forms, clinical notes and templates

[Authorisation of seclusion form](#)

[Reduction and elimination plan](#)

[Return to and release from seclusion form](#)

Referenced documents and sources

[Chief Psychiatrist Policy: Seclusion.](#)

[Mental Health Act 2016](#)

Document status summary

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Attachment 1 – Key contacts

Key contacts	
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