Chief Psychiatrist Practice Guidelines

Seclusion

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Overview

- These Practice Guidelines:
  - set out procedures for authorised mental health services (AMHS) regarding seclusion of a patient under the *Mental Health Act 2016* (MHA 2016)
  - are to be read in conjunction with the relevant provisions of the MHA 2016 (Chapter 8) and the *Chief Psychiatrist Policy: Seclusion*, and
  - are mandatory for all AMHS staff exercising a power or function under the MHA 2016.

Key information

- The MHA 2016 makes provision for a range of safeguards and restrictions in relation to the use of seclusion in an AMHS that promote the national and state priority of reducing and where possible eliminating seclusion.
- 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.
- It is an offence to seclude a person in an AMHS other than in accordance with the MHA 2016.
- Authorised mental health services must comply with any written direction given by the Chief Psychiatrist about seclusion.

Definitions

*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 Practice Guideline.

*Health practitioner* – means a person registered under the Health Practitioner Regulation National Law, or another person who provides health services, including, for example a social worker.

*Health practitioner in charge of the unit* – means the health practitioner who has clinical responsibility for the unit where the patient is being secluded (e.g. the nurse unit manager, or senior registered nurse in charge).

*Reduction and Elimination 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, for a period of not more than 10 hours between 8:00pm and 8:00am.
Guidelines

1 Application of the seclusion provisions

- Only a ‘relevant patient’ may be secluded under the MHA 2016 in an AMHS.
- A relevant patient is a person subject to:
  - a Treatment Authority
  - a Forensic Order
  - a 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 MHA 2016.
- Seclusion may be authorised in any unit within an AMHS, including an emergency department, provided the room or area complies with the Chief Psychiatrist Policy: Seclusion and sufficient resources are available to safely meet the needs of the patient.
- Seclusion authorised under the MHA 2016 must be recorded on the patient's file in CIMHA. The Administrator of the AMHS must ensure that procedures are in place within their service to ensure these records are maintained.
- Mechanical restraint must not be used on a patient in seclusion.

2 Process for authorising seclusion

2.1 General

- Seclusion may be authorised for up to 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.

2.1.1 Authorised doctor responsibilities

- 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 the *Chief Psychiatrist Policy: Seclusion*

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* form (where a 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 hours
  - specific measures to ensure the health, safety and comfort of the patient
  - observation requirements while the patient is 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 seclusion requires a new authorisation. However, a patient’s total hours in seclusion must not exceed 9 hours in a 24 hour period (refer to section 2.2 Restrictions on authorisation). A 24 hour period commences from the first time the patient is placed in seclusion.

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

- Observation for seclusion must be continuous or at intervals of no more than 15 minutes. This must be determined by the authorised doctor based on clinical assessment. However, Aboriginal and Torres Strait Islander people must be continuously observed while in seclusion.

- A medical review of the patient, by an authorised doctor, is required at the end of each authorised period of seclusion (e.g. after 3 hours of seclusion, or earlier). The medical review should occur as soon as practicable after the seclusion period ends (e.g. 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 doctor’s examination should include a physical examination (if clinically appropriate and safe to do so) and must consider whether seclusion should be continued or ceased. The outcomes of the review must be recorded in the patient’s clinical record. Wherever possible this should be on CIMHA.

### 2.1.2 Health practitioner in charge of unit responsibilities

- The health practitioner in charge of the unit has responsibilities to ensure the seclusion authorisation 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.
2.2 Restrictions on authorisation

- 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 9 hours in a 24 hour period unless:
  - an approved Reduction and Elimination Plan for the patient provides for seclusion in excess of 9 hours in a 24 hour period (refer to section 2.3 Extension of period of seclusion), 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.

2.3 Extension of period of seclusion

- A single extension to seclusion of up to 12 additional hours may be made when:
  - seclusion has or is likely to exceed 9 hours in a 24 hour period, and
  - an approved Reduction and Elimination Plan is not yet in place.

- The purpose of the extension is to allow for the development and approval of a Reduction and Elimination Plan form.

- An extension requires:
  - the approval of the Clinical Director (or delegate), and
  - authorisation by an authorised doctor.

- For example, it is 9:00pm, a patient has been in seclusion for 7 hours within the 24 hour period and it has not been possible to complete a Reduction and Elimination Plan. By 11:00pm, the patient will have been in seclusion for 9 hours. 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 Reduction and Elimination Plan must then be developed and approved by the time the extension expires at 11:00am.

- An extension of seclusion may only be granted once for each period of the admission in which the patient requires acute management. For example:
  - a patient admitted to an AMHS on an inpatient authority or order may require seclusion as part of acute management during the first week of the admission. A seclusion extension is granted to allow time for the development of a Reduction and Elimination Plan. The Plan is approved for a 3 day period. Subsequently, the acute management phase is successfully resolved and the patient continues their admission for a further four weeks. In the fourth week of the admission, the patient again requires seclusion as part of an acute management response. If required, to allow time for approval of a new Reduction and Elimination Plan form, a seclusion extension may again be granted, as it relates to a separate acute phase for the patient. Note that in this...
example, two separate acute management 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.

- during a patient's admission to an AMHS on an inpatient category order, an extension of seclusion is authorised, and a Reduction and Elimination Plan is developed. Once stable, the patient is discharged from the inpatient unit. The patient then returns to the emergency department and requires another admission and a further period of seclusion. In this case, an extension to seclusion could be granted, if required, to enable the development and approval of a new Reduction and Elimination Plan form.

- The timeframes and scenarios outlined above are examples only. 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.

2.3.1 Authorised doctor responsibilities

- 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 the Chief Psychiatrist Policy: Seclusion
  - 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 Reduction and Elimination Plan form to be approved during the 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 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 provided on the Extension of Seclusion form.

- If it appears that an extension to seclusion is likely to be required (e.g. it is late evening, a patient has been in seclusion for 7 hours within the 24 hour period and it has not been possible to complete a Reduction and Elimination Plan form), the Extension of Seclusion form can completed before it is required; provided this
occurs within a reasonable timeframe and is for the purposes of 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
  - 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 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 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.

### 2.3.2 Health practitioner in charge of unit responsibilities

- The health practitioner in charge of the unit has responsibilities to ensure the seclusion authorisation 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.

### 3 Reduction and Elimination Plans

- The **Reduction and Elimination Plan** form is available within the MHA module in CIMHA. If the form is not completed on CIMHA, it must be uploaded and recorded on the patient's clinical file on CIMHA.

- It is recommended practice for a **Reduction and Elimination Plan** to be in place in all instances where a patient is secluded. However, an approved Plan **must** be in place for any patient secluded for more than 9 hours in a 24 hour period.

- The Chief Psychiatrist may also direct, on his/her own initiative, that a 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.

- An authorised doctor must apply to the Chief Psychiatrist for approval of a **Reduction and Elimination Plan**.

- The Chief Psychiatrist may delegate the authority to approve a **Reduction and Elimination Plan** for seclusion to the Clinical Director (or another senior clinician of the AMHS). The Clinical Director (or delegate) may only approve the first 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 9 hours in a 24 hour period may be necessary.

- Where a Plan is submitted to the Chief Psychiatrist, the Office of the Chief Psychiatrist will review the proposed Plan and make a recommendation to the Chief Psychiatrist regarding whether the Plan should be approved. As part of this review, the Office of the Chief Psychiatrist may contact the authorised doctor making the application for further information.

- Where a Plan is submitted to the Chief Psychiatrist, the Clinical Director and authorised doctor will be advised in writing of the Chief Psychiatrist's decision as soon as possible, but within 2 working days of receiving the Plan.

- In urgent circumstances the Chief Psychiatrist 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
  - the reasons for use of seclusion, and
  - the planned use of seclusion and strategies for the reduction and elimination of use.

- A full Reduction and Elimination Plan form must be provided to the Chief Psychiatrist as soon as practicable and within 24 hours of the email approval being provided.

- A Reduction and Elimination Plan must not be approved for longer than 7 days. If a patient requires seclusion for a period beyond 7 days, a new Plan must be submitted to the Chief Psychiatrist for approval. A Clinical Director cannot approve subsequent Plans.

- The timeframe of an approved Reduction and Elimination Plan form cannot be extended. If the patient requires seclusion beyond the approved period of authorisation, a new Reduction and Elimination Plan form must be submitted to the Chief Psychiatrist.

- A Reduction and Elimination Plan form 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 on 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 Plan
  - the strategies proposed to reduce and eliminate the use of seclusion.
The approval of a **Reduction and Elimination Plan** does not replace 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 3 hours as required under the **Chief Psychiatrist Policy: Seclusion** and section 2 (Process for authorising seclusion) of this Guideline.

A single **Reduction and Elimination Plan** may apply to both mechanical restraint and seclusion. Note that only the Chief Psychiatrist may approve a **Reduction and Elimination Plan** form that covers both seclusion and mechanical restraint, or mechanical restraint alone. However, seclusion and mechanical restraint must not be used simultaneously.

## 4 Removal from seclusion

- The 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.

- 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 **Release and Return to Seclusion** form which should then be uploaded onto the patient's clinical record on CIMHA.

- The Chief Psychiatrist may also direct an authorised doctor or health practitioner in charge to remove a patient from seclusion if the Chief Psychiatrist is 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.

- 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 the seclusion.

- In addition, a review (or debrief) with the patient, and where appropriate their support person/s, must be undertaken as soon as is clinically appropriate after the seclusion ends, in order to:
  - enable open discussion about the seclusion and the events leading to it
  - allow the patient to ask questions
  - provide an opportunity to identify strategies that may assist in preventing the need for seclusion in the future.
• 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 evaluate:
  – the triggers which resulted in the need to use seclusion, and
  – the methods used to respond to the need for seclusion.
5 Emergency seclusion

5.1 General

- A health practitioner in charge of a unit within an AMHS may authorise seclusion for up to 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).

- During emergency seclusion, the patient must be continuously observed.

- Emergency seclusion must not be authorised if the total period of emergency seclusion is, or will reach under the authorisation, more than 3 hours within a 24 hour period. A total of 3 hours in a 24 hour period may be reached when a patient is secluded on a number of separate occasions of up to an hour each (totalling 3 hours), or when a patient has been secluded 3 times consecutively for an hour each time.

5.1.1 Health practitioner in charge of unit responsibilities

- To authorise seclusion in an emergency, the health practitioner in charge must complete the Emergency Authorisation of Seclusion form.

- The Emergency Authorisation of Seclusion form must be completed electronically in 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 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.

5.1.2 Authorised doctor responsibilities

- The authorised doctor who 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 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.

6 Notifications and recording

• 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 guideline and the Chief Psychiatrist Policy: Seclusion.

• 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 24 hours following seclusion of the patient
  – significant harm to a patient or other person during seclusion or within 24 hours following seclusion of the patient.

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

• Each time a 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
  – any Reduction and Elimination Plan form approved by the Chief Psychiatrist or where delegated, a Clinical Director of the AMHS.

• In addition, the following information must be recorded in the patient’s clinical record. Where possible, this should be 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 intoxication 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.
Glossary of Terms

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Referenced Forms, Clinical Notes and Templates

- Authorisation of Seclusion form
- Emergency Authorisation of Seclusion form
- Extension of Seclusion form
- Reduction and Elimination Plan form
- Return to and Release from Seclusion form

Referenced Documents & Sources

- Chief Psychiatrist Policy: Seclusion
- Health Practitioner Regulation National Law
- Mental Health Act 2016

Document Status Summary

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