Seclusion

Chief Forensic Psychiatrist Clinical Guideline 9

Provisions to Which the Order Relates

Mental Health Act 2013 – sections 3, 15, 92, 94, 96 and Schedule 1(extracted at Appendix 1).

Preamble

Seclusion is an extremely restrictive intervention. Its application may cause distress for patients, support persons and staff members.

For this reason seclusion may only lawfully be applied when less restrictive interventions have been tried without success, or have been considered but excluded as inappropriate or unsuitable in the circumstances.

The need to ensure that seclusion is an emergency intervention that is used only where necessary has been recognised by the United Nations through the *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* which provide that:

Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others.

This approach is reflected in national trends. For example, Standard 1 of the National Standards for Mental Health Services 2010 requires the safety and dignity of the person being secluded to be protected at all times with any interference with the person's rights, dignity, privacy or self-respect to be kept to a minimum.

Purpose

This Clinical Guideline is intended to help controlling authorities, medical practitioners, nurses and other staff members of secure mental health units in the exercise of responsibilities relating to the seclusion of forensic patients under the *Mental Health Act 2013*, and related matters.

The Guideline is designed to ensure that seclusion is used appropriately, safely and in a manner that respects the dignity and rights of patients.

Failure by an individual to have regard to this Clinical Guideline is not an offence but may, particularly if it leads to unfavourable patient outcomes that might otherwise have been avoided or if there is a history of such disregard, constitute proper grounds for instituting professional or, as the case may be, occupational disciplinary action against that individual.

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Guideline

I, Professor Kenneth Clifford Kirkby, being and as the Chief Forensic Psychiatrist, pursuant to sections 151 and 153 of the *Mental Health Act 2013* and section 22 of the *Acts Interpretation Act 1931* hereby:

1. Revoke all previous directions (clinical guideline) issued under section 152 of the *Mental Health Act 2013* with respect to the exercise of responsibilities relating to the seclusion of forensic patients with effect from 11.59 pm on 30 June 2017; and

2. Issue the following direction (clinical guideline) to controlling authorities (and delegates), authorised persons and other secure mental health unit staff members exercising responsibilities in relation to the seclusion of forensic patients under the *Mental Health Act 2013*, and related matters, with effect from 12.00 am on 1 July 2017.

What is seclusion?

Seclusion may be understood as the deliberate isolation of a forensic patient from others, without the patient's consent, in an environment that they cannot leave without the agreement or assistance of another person. This includes circumstances where a patient is isolated in any completely enclosed area, whether consisting of one or more compartments or rooms, of which any doors or windows are locked from the outside.

Although the formal definition of seclusion does not include situations where someone prevents a person from leaving a room by, for example, physically blocking the exit, the principles in this Guideline should be complied with to the extent that they are relevant in such situations.

The principles set out in this Guideline should also be followed in relation to time-out processes for children and adults that have the features of seclusion.

Reducing the Use of Seclusion

While seclusion can provide safety and containment at a time when this is needed to protect forensic patients, staff and others, it can also be a source of distress not only for the patient but also for support persons, representatives, other patients, staff and visitors.

Wherever possible, alternative, less restrictive ways of managing a patient's behaviour should be used, and the use of seclusion minimised. This can be achieved through the adoption of a prevention and early intervention framework.

Prevention and early intervention practices rely on reducing the risk factors for aggression or violence as well as enhancing the protective factors that promote a safe, secure, understanding and accepting environment.

Mental health care and the environment in which it is delivered are intended to optimise the safety and wellbeing of patients. Prevention and early intervention activities are aimed at improving the overall experience of patients and include, for example, strategies aimed at building connectedness, inclusion and a sense of acceptance.

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Appropriate prevention and early intervention strategies can assist to reduce the circumstances in which the need to seclude a patient arise. A range of these strategies are included in this section of the Guideline.

Inclusion of Patients and Support Persons

There is a greater chance of avoiding the need to use restrictive interventions when inpatient care involves patients, their representatives and support persons.

It should not be assumed that patients, or their representatives or support persons will be aware that the person may be secluded while a forensic patient.

On admission of a person to a secure mental health unit, every effort should be made to provide information about seclusion practices, particularly where the patient has a history of, or potential for, aggression, or where there are concerns related to the safety of others. In practice this may be achieved through providing patients with access to this document and to Chief Forensic Psychiatrist Standing Order 9: Seclusion.

Staff should listen to concerns expressed by patients, and by their representatives and support persons about the use of seclusion and should provide information which may address concerns, and answers to any questions asked, whenever needed.

While it is appropriate to provide information to representatives and support persons in this way care should be taken to ensure that information which is specific to the patient and their seclusion is provided to others only when the patient consents.

Seclusion Care Planning to Minimise the Risk of Seclusion or Repeat Seclusion

Care planning that takes into consideration individual patient needs, preferences and experiences of which interventions are most effective should occur in relation to seclusion for all patients.

Seclusion care planning should consider the patient's primary diagnosis and involve an assessment of the patient's clinical needs, treatment objectives and outcomes, management of any underlying conditions, appropriate communication with the patient about what behaviours are unacceptable, and incorporate the development of a written seclusion management or safety plan for the issues identified. The plan should in particular address individual patient, staff and environmental triggers.

In circumstances where seclusion is likely to be necessary, planning should also consider the individual's safety and care needs during seclusion, particularly for patients who are assessed as likely to present with acutely disturbed or aggressive behaviours, for those who require repeat episodes of seclusion or where there is considered to be a need to seclude a patient who is extremely disturbed immediately after the patient's admission to hospital.

Care planning should also involve:

- Identifying mental and physical health problems and risks, and how they are to be managed
- Determining the frequency and nature of clinical observations required to be performed. This may include physical (respiration, pallor or cyanosis, posture, level of consciousness, motor activity, blood pressure and pulse) and mental state (pattern and content of speech, thought content, mood, affect, concentration, attention and level of motor activity) observations
- Identifying the time and frequency of medical examinations required to be performed
- Identifying the patient's bedding and clothing needs and how these are to be met
- Identifying the patent's need to have access to communication or physical aids while in seclusion and an indication of how these needs are to be managed
- Identifying the patient's hygiene and toileting needs and making arrangements for these to be met
- Identifying the patient's dietary needs and arranging for these to be met. At a minimum this should involve fluid being offered to the patient at least every two hours and food being offered at least every four hours, except overnight when this may not be desirable. It may be appropriate for the patient to be supplied with a plastic cup and container of water. A fluid balance chart should be commenced for a patient who has been secluded for more than four hours
- Establishing when the care plan itself should be reviewed.

Where seclusion is used for extended periods of time or on a recurrent basis, it is good clinical practice to obtain a second opinion or hold a case conference to review the patient's management as soon as practicable.

Diagnosis and Management of Underlying Conditions

Patients who repeatedly behave in a manner that threatens themselves or others and whose symptoms fail to respond to a full range of clinical interventions pose particular clinical challenges. Careful consideration and management may be required.

A thorough review of the patient's history, treatments attempted and their duration, and doses of medication administered and the patient's responses to these should be undertaken by the treating team, and may be the subject of a case conference. A second opinion external to the treating team may also be sought.

Any seclusion management or safety plan that is developed for the patient should describe the behaviour in question; should identify, wherever possible, the precipitating and exacerbating factors; and should suggest a graded series of responses. The plan should include strategies aimed at reducing the behaviour and the need for such restrictive interventions.

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Advance Safety Plans for Seclusion Episodes

For those who are at high risk of seclusion or who have been secluded in the past, a collaborative advance safety plan for seclusion may be useful.

This should address patient concerns and vulnerabilities. For example, a patient with a history of a specific form of assault may become agitated if physical restraint that reminds them of this assault is used. In other instances a patient may prefer oral rather than intramuscular medication when severely distressed.

Managing Seclusion

Communication Considerations

A patient for whom seclusion is authorised should be told that he or she is being secluded, and should be informed of the period for which seclusion has been authorised. Any extension of this period should be similarly communicated.

Attempts should be made to inform a patient's representatives and/or support persons that the patient has been secluded as soon as practicable after the period of seclusion commences, and of the period for which seclusion has been authorised, to the extent that this is consistent with the patient's wishes. Information and support should be offered to representatives and/or support persons as and when needed.

The Act requires a patient who has been secluded to be given a statement of rights as soon as practicable after the decision is made to commence seclusion. This requirement may be discharged while the patient is in seclusion or at a later point. Consideration should be given to having a member of nursing staff read the statement to a patient who is significantly unwell and/or considered otherwise unlikely to fully understand the content of any written statement that is provided, pending the provision of a written statement to the patient once this is considered to be clinically appropriate.

Clinical Considerations

A patient for whom seclusion is considered to be necessary should be thoroughly medically assessed. This should occur either prior to or as soon as possible after a patient is secluded.

Particular emphasis should be placed on seeking a history of the presentation from the patient and their support persons, as well as other relevant/significant people. This should include information about the possible ingestion of alcohol, illicit drugs, over-the-counter medication and prescription medication that may have been ingested as a deliberate or accidental overdose. Information on medication prescribed should also be obtained.

The assessment should be as thorough as the circumstances allow and should include an assessment of the risk to the patient from deliberate or accidental self-harm.

Medication Considerations

The Act requires the administration of any prescribed medication to a patient who is secluded, not to be unreasonably denied or delayed.

In circumstances where it is difficult to thoroughly medically asses the patient, the risk of adverse effects from medication is greatly increased. Factors to be taken into account in deciding whether or not prescribed medication should be given include the safety and wellbeing of the patient, the likely interaction of the medication with any other medication already prescribed and administered, the patient's ongoing management needs, whether giving the medication is consistent with achieving the best treatment outcomes in the shortest possible time, and the safety of other patients and staff if the medication is given or is not given.

Medical staff prescribing for people who are or may be secluded must be familiar with the possible adverse effects of any medication prescribed and the cumulative effects of the medication from repeated administration. Prescribing psychotropic medication should be in accordance with accepted guidelines.

Staff should in particular be aware that the use or withdrawal from benzodiazepines, tobacco or other drugs may heighten anxiety and aggression in some people.

Use of Security Personnel

Security staff involved in seclusion procedures should be under the direct authority and supervision of the senior registered nurse on duty or medical practitioner present, at all stages of a patient's seclusion.

Any concerns about the individual practices of staff involved in these procedures should be escalated to a senior manager.

Special Considerations

Patients with a History of Trauma

Seclusion can trigger extreme responses from some individuals, including those who have a history of trauma. Responses may include flashbacks, hallucinations, dissociation, aggression, self-injury and depression.

Patients with a history of trauma who are secluded may feel they are being punished. They may be confused by the use of force by staff and may feel unsafe and unprotected from harm. They may also feel bitter and angry.

Research suggests a very high prevalence of traumatic experiences in persons who receive mental health services. A majority of adults and children in inpatient psychiatric treatment settings present with trauma histories and there are certainly others whose trauma histories haven't become known yet.

For this reason, as a universal precaution, it should be presumed that every person in a treatment setting has been exposed to trauma.

Advance safety plans may also be particularly useful for patients with an identified history of trauma.

Patients Who Are Suicidal

The use of seclusion for persons who are suicidal is likely to be counter therapeutic. Consideration should be given to the use of one-to-one nursing care in such situations.

Gender Safety and Sensitivity

Given the high incidence of previous experiences of trauma among forensic patients and given that restrictive practices such as seclusion may potentially retrigger previous experiences of trauma in some people, services should ensure that staff demonstrate sensitivity to individual patient's needs and wellbeing in carrying out such interventions, particularly with regard to gender.

For example, seclusion may be experienced by the patient as particularly traumatic or humiliating where nursing and security staff are predominantly male or female. As such, different patients may have different preferences about the gender of staff involved in the intervention. Where possible, the patient's preferences should be sought and responded to.

Arrangements for clothing, toileting and observation and examination requirements should also be undertaken in regard to their gender sensitivity.

Consideration should also be given to the possibility of pregnancy in female patients and the implications of this, especially for the use of medications.

Patients with Intellectual Disability or Acquired Brain Injury

A patient with an intellectual disability or acquired brain injury may communicate primarily through their behaviour. This may particularly be the case where other means of communication are impaired by mental illness.

Problematic behaviour from people with intellectual disability or acquired brain injury should be assessed, wherever possible, for meaning before the decision is taken to use seclusion.

Staff should always assess the patient's mental state and consider that the patient may be experiencing hallucinations or mood disturbance. It is also important to consider mental state abnormalities resulting from an underlying illness that may be exacerbating a patient's behaviour.

It is important, wherever possible, for the nature of the intervention and the reasons for it to be explained at a level the patient is able to comprehend, preferably before the patient is secluded.

It is also important to consider the existence and involvement of the patient's representatives, including guardians.

Providing a safe and quiet room to which a patient with a disability might withdraw should be considered as an alternative to seclusion, for example, providing a single-occupancy bedroom on the unit.

More severe levels of cognitive impairment and autism spectrum disorders are sometimes risk factors for the use of seclusion and in these circumstances clinicians should be alert to the need for increased support to avoid the use of seclusion wherever possible. There is the possibility that people with autism may prefer isolation to having to manage the unpredictable environment of the inpatient unit and may actively seek seclusion. Staff should be alert to this and find alternatives to seclusion.

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Patients with cognitive impairment often have difficulty in understanding the rationale for the use of seclusion and may react with an escalation in agitation during this process. Self-injurious behaviour is also unlikely to be abated by a period of seclusion.

Where agitated or violent behaviour is a new phenomenon, the patient should be carefully assessed for an underlying medical condition.

Children and Adolescents

The developmental status of a young person should be a consideration in any decision to seclude.

In all cases, seclusion of children under the age of 12 years should be avoided.

While the parent or guardian of a young person should be informed of an episode of seclusion as soon as practicable and involved in the debriefing process wherever possible, a decision to involve a parent or guardian must take into account the child's capacity to consent to their involvement, and the child's views about this. This may involve considering whether or not the child is capable of fully understanding the nature and consequences of the decision to involve the parent and the child's ability to communicate his or her decision.

Careful assessment by a trained child and adolescent clinician is required (especially for those children and adolescents with histories of trauma and abuse) where other strategies to de-escalate behaviours are more appropriate than the use of seclusion.

Older Persons

Disturbed behaviour in older people – particularly those with dementia – may be a result of medical illness, physical discomfort, sensory impairment or the presence of unmet needs which cannot easily be communicated to staff.

Particular care should be given to supporting older patients to communicate through use of short, clear sentences in a lower tone of voice, employing active listening skills to hear what the patient may be trying to communicate.

The possibility of delirium must be considered in the assessment of any older patient who is becoming agitated, distressed or confused or for whom seclusion is being considered. Matters which may be associated with delirium such as hypoxia, hypertension, hypoglycaemia, major electrolyte disturbance, infection, urinary retention, constipation and faecal impaction along with pain, thirst, hunger and alcohol withdrawal syndrome should considered along with any other clinical factors that may require management including depression or anxiety and any new neurological deficits.

At times a person's distress may be reduced through the application of comfort factors including positioning, immobility, provision of communication aids including hearing aids or glasses, activity to alleviate boredom, toileting needs, thirst, loneliness or lack of activity, or modification of environmental factors such as noise, temperature or lighting.

The vulnerability of older patients – particularly the increased risk of falls - should be a consideration in any decision to seclude and should be taken into account in the seclusion process.

Communication with Patients from Culturally and Linguistically Diverse Backgrounds

Seclusion may be more traumatic and potentially more dangerous for those who are unable to understand what is happening or unable to communicate their questions or concerns. The use of professional interpreters must be considered in these situations.

Patients may perceive or interpret the use of force differently depending on their cultural backgrounds and personal experiences as a refugee or a survivor of abuse or torture.

It is important to be aware that communication problems in themselves may lead to unnecessary interventions. Special care should be taken to achieve effective communication, first to avert the use of seclusion, if possible, and second, to minimise the trauma of the intervention to the patient both during and after the intervention. The use of interpreters and availability of communication aids whilst the patient is in seclusion should be considered in these situations.

Every effort should be made to understand and respond to cultural sensitivities by, for example, providing language services and by taking into account the gender of direct care staff.

Communication with Patients with Sensory Impairment

Seclusion may also be more traumatic and potentially more dangerous for patients who may be unable to understand what is happening or unable to communicate their questions or concerns due to sensory impairment. Specific interventions, such as the restraint of a deaf person's hands, may also prevent effective communication.

Special care should be taken in these situations to achieve effective communication, first to avert the use of seclusion, if possible, and second, to minimise the trauma of the intervention to the patient both during and after the intervention. The use of staff members who are familiar with the communication needs of the patient and the availability of communication aids required by the patient to communicate on a daily basis should be considered in these situations.

Voluntary Patients and "Time Out"

A voluntary patient cannot be lawfully secluded under the *Mental Health Act 2013*.

Confinement of a voluntary patient who is lawfully capable of giving or withholding consent alone in a room without the patient's consent may have significant legal consequences.

However, a voluntary patient who is legally capable of consenting may consent to being locked alone in a room, provided the patient is capable of ending his or her confinement as and when the patient so requests. In most cases this will involve the room being unlocked as soon as this is requested by the patient.

The patient's written consent to being confined should be obtained, prior to the confinement commencing. This should be accompanied by a written statement from the patient's treating medical practitioner or a senior nurse on duty confirming the patient's capacity to provide consent to his or her confinement.

Should the behaviour of a voluntary patient meet the criteria for being placed in seclusion, consideration should be given to whether the patient meets the assessment or treatment criteria with steps taken to obtaining an Assessment Order or Treatment Order if this is the case.

Observation and Examination Requirements

Once the decision has been made to use seclusion, careful assessment of the patient's safety needs is essential, together with clinical monitoring, support and review.

Communication with the Treating Team

A senior member of the immediate treating team should be informed of a patient's seclusion as soon as is reasonably practicable in order to inform ongoing management decisions associated with the patient.

Clear systems and processes should be in place to communicate to relevant clinical staff across successive shifts. In particular, details regarding the reasons for the use of seclusion, the current plan and previous treatments provided should be clearly communicated at handover points and be available in the clinical record. The clinical record should contain up-to-date documentation such as risk assessments, seclusion management or safety plans, observation charts, medical reviews and communication with other parties - for example, support persons.

Where continuous observation is clinically indicated, a monitoring nurse must be stationed outside the seclusion room, with observation occurring via the observation panel in the door.

A clinical observation should involve monitoring the patient's vital signs and symptoms to ensure that the patient is clinically safe, and comfortable. The observation should also involve an assessment of the patient's mental and physical status and the continuing need for seclusion.

In cases where large doses of medication have been given, more detailed observations may be needed so that potential side effects can be identified. In such instances periodic observation and examination from within the seclusion room of vital signs, muscle tone and level of consciousness may be necessary.

Each examination should be as thorough as the circumstances permit, and should cover the patient's mental and physical health status and include an assessment of the need to continue the seclusion based on the criteria contained in the Act. If it is considered likely that the patient may need to be secluded for a period of more than 12 hours the examination should also involve an assessment of the benefits and detriments considered to be associated with continuing seclusion for an extended period.

Particular emphasis should be placed on seeking a history of the patient at the first examination.

This should include information about the possible ingestion of alcohol or illicit drugs, and of deliberate or accidental overdose of prescribed medications, and any history of suicide attempts by the patient, and involve:

- A review of the patient's physical and mental health status
- An assessment of the adverse effects of medication
- A review of the observations required with respect to the seclusion
- A reassessment of the medication prescribed
- An assessment of the risk to the patient from deliberate or accidental self-harm
- An assessment of the need for continuing seclusion.

Occasionally a patient whose mental state and reasoning is profoundly impaired by their illness is admitted to an inpatient unit. Patients in this state may be unable or unwilling to give coherent responses to questions and/or are aggressively opposed to being physically examined. While this makes adequate assessment difficult, as thorough an assessment of the patient as is possible should take place before any medication is administered.

Staff must be alert to the possibility that the patient who appears to be asleep may actually be unconscious. Where a patient appears to be asleep in seclusion, clinical staff should be alert to and assess the level of consciousness and respirations of the patient to exclude the possibility of an altered level of consciousness or respiratory distress.

Ending Seclusion

Opening the door for toileting, food and fluids or medical examination does not constitute the end of a period of seclusion. Additionally, such breaks must not be used to remove the requirement for a four-hourly medical examination.

Whether or not to end a period of seclusion is a clinical decision made by clinical staff; and if clinical staff on duty believe that seclusion is no longer necessary then it must be ceased immediately.

If a decision has been made to cease an episode of seclusion and subsequent behaviour indicates the need to recommence seclusion, this requires a new approval or authority.

People who are Asleep When Seclusion Ends

If a patient is asleep during seclusion, clinical staff should assess whether it is appropriate to end the seclusion episode. In such instances seclusion may be ended by leaving the door ajar and unlocked and allowing the patient to continue sleeping, if it is safe to do so.

Consideration should be given to the patient's possible reaction on waking. In particular the door is to be left ajar in a way that makes it clear to the patient that the door is open and that they can exit of their own volition.

The door should remain locked until the patient wakes and can be assessed only if there is a substantial continuing risk or doubt about the immediate or imminent risk to the patient's health or safety or to the safety of others.

Post-Seclusion Patient Support

Although seclusion may be used for sound clinical reasons, it is a potentially traumatic intervention that requires sensitivity and skill in its management.

Once the patient is settled and willing to discuss the incident leading to seclusion, the patient's understanding and experience of the incident should be explored and the reasons seclusion was used and other interventions deemed ineffective or inappropriate explained to the patient.

The patient should be allowed to discuss their experience of being placed in seclusion, their experience of seclusion reviews, receiving medication (if given), and the time they spent in seclusion.

Staff must be aware that the purpose of a post-seclusion discussion with the patient is to provide an opportunity for the individual's experience of the episode to be discussed. Attempts by staff to justify the decision to restrain or seclude may be counterproductive.

The patient should be given a choice as to who they would like to discuss their experience with, wherever possible.

Consideration should be given to the sensitive reintegration of the patient into the general inpatient population because patients might consider seclusion as embarrassing or humiliating.

Clinical staff members also need to be aware of how the patient and others in the inpatient unit are affected by the use of seclusion. Staff should offer information on seclusion to visitors and to other people (including other patients) who have witnessed a seclusion event.

Documentation and Review

Following the cessation of a seclusion episode, a formal seclusion review meeting should occur as soon as possible. This should involve at least the unit manager, senior registered nurses and consultant psychiatrist.

Wherever possible, the patient and his or her support persons and representatives should be encouraged to participate in the relevant parts of the review process.

The aim of the seclusion review meeting is to:

- Review the seclusion episode including the lead up to the seclusion
- Identify preventative strategies trialled and the reasons for failure
- Review compliance with the Act
- Review system-wide management issues that may need addressing to prevent further seclusion episodes
- Consider what else might have been done to prevent or minimise the disturbed behaviour
- Update clinical risk assessments relating to the patient and the patient's care plan.

Any systemic issues identified in the formal review are to be forwarded to the relevant safety and quality improvement committee for attention.

Guidance for Controlling Authorities

Controlling authorities of secure mental health units should consider the requirements of the *Mental Health Act 2013* when designing or designating rooms or areas which may potentially be used as seclusion rooms or seclusion spaces. In particular controlling authorities should consider matters such as ventilation and light, and the ability for patients secluded within such rooms or spaces to seek help from nursing or medical staff members.

Controlling authorities should also consider putting in place processes to ensure that patients in seclusion are able to keep track of time.

Controlling authorities should also ensure that staff members who are required, or potentially required, to exercise functions and powers relating to seclusion are educated and trained on the safe use of seclusion and on the requirements of the *Mental Health Act 2013* as it relates to seclusion. This includes contracted security personnel.

Controlling authorities should consider including the following matters within the scope of quality assurance and review activities:

- The extent to which staff know how to apply the framework established by the Act and are aware of this Guideline, relevant Chief Forensic Psychiatrist Standing Orders and any local policies and procedures associated with seclusion
- The reasons underpinning the application of seclusion
- The prolonged or repeated use of seclusion
- The use of seclusion overnight
- Risk assessments conducted prior to and during seclusion
- Injuries or other incidents occurring in the lead up to seclusion, or during seclusion
- Seclusion care planning and advance safety planning
- The use and effectiveness of strategies to reduce the use of seclusion
- The use of medication in respect of patients who are secluded
- Patient and support person perceptions of seclusion.

Findings from activities conducted should be used to inform the development of training programs for staff.

Guidance for Clinical Staff

Staff members working within secure mental health units should ensure that they have a sound knowledge of the *Mental Health Act 2013*, this Guideline, relevant Chief Forensic Psychiatrist Standing Orders and of any local policies and procedures relating to the use of seclusion which may be in place from time to time.

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Staff members who are directly involved in the provision of patient care should ensure that they receive specific training in how to ensure that seclusion is applied minimally and safely, and in de-escalation techniques.

Staff likely to be involved in the use of seclusion should also ensure that they receive training in observation and monitoring of patients who are secluded and recognising signs of mental and physical distress in a patient who is secluded.

At the completion of training staff should be able to demonstrate an understanding of:

- Legislation governing the use of seclusion in Tasmania
- How patients experience seclusion
- Underlying causes of aggressive or threatening behaviours
- Aggressive behaviours that may be related to a medical condition
- The impact of their own behaviours and attitudes on patients
- Use of de-escalation techniques

Professor Kenneth Clifford Kirkby

Chief Forensic Psychiatrist

Date: 1 July 2017

Appendix 1: Relevant Legislative Provisions

3. Interpretation

adult *means a person who has attained the age of 18 years*

approved facility *means an approved hospital, an approved assessment centre or a secure mental health unit.*

approved medical practitioner *means a person who has been approved by a Chief Psychiatrist under section 138 of the Act.*

approved nurse *means a person who has been approved by a Chief Psychiatrist under section 138 of the Act.*

Chief Forensic Psychiatrist *means the person for the time being holding or acting in the office referred to in section 144 of the Act. The Chief Forensic Psychiatrist has responsibility for ensuring that the objects of the Act are met in respect of forensic patients and persons admitted to a secure mental health unit pursuant to section 63 of the Act, for persons who are subject to supervision orders, and for the running of secure mental health units.*

child *means a person who has not attained the age of 18 years*

communication aid *means any electronic or other device used to assist a person to communicate*

controlling authority *means –*

> *(a) for an approved facility run by or on behalf of the State, the Secretary; and*
>
> *(b) for any other approved facility, the person for the time being in overall charge of the day-to-day clinical management of that facility*

forensic patient *means a person admitted to a secure mental health unit under section 68 of the Act and not discharged from the secure mental health unit*

general health care *means medical, dental or other health treatment not primarily aimed at the treatment or alleviation of mental illness*

parent*, of a child, means a person having, for the child, all of the responsibilities which, by law, a parent has in relation to his or her children*

physical aids *includes –*

> *(a) spectacles and hearing aids; and*
>
> *(b) prostheses; and*
>
> *(c) inhalers, ventilators and oxygen apparatuses; and*
>
> *(d) crutches, wheelchairs and walking frames*

representative*, of a patient or prospective patient, means –*

> *(a) the patient's guardian; or*

(b) the patient's Australian lawyer; or

(c) if the patient is a child and raises no objection, a parent of the patient; or

(d) any other person nominated by the patient to represent his or her interests

restriction order *means a restriction order made under the Criminal Justice (Mental Impairment) Act 1999 or Sentencing Act 1997*

seclusion *means the deliberate confinement of an involuntary patient or forensic patient, alone, in a room or area that the patient cannot freely exit*

secure mental health unit *means a secure mental health unit approved to assess or treat forensic patients, under section 140 of the Act.*

statement of rights *means a written statement that sets out and succinctly explains, in plain language, what rights a patient or prospective patient has in the particular circumstances under this Act in which he or she is required to be given such a statement*

supervision order *means a supervision order made under the Criminal Justice (Mental Impairment) Act 1999 or Sentencing Act 1997*

support person*, of a patient or prospective patient, means a person who provides the patient with ongoing care or support*

treating medical practitioner *means the medical practitioner who is responsible for a patient's treatment or proposed treatment*

treatment *means the professional intervention necessary to prevent or remedy mental illness; manage and alleviate, where possible, the ill effects of mental illness; or reduce the risks that persons with mental illness may, on that account, pose to themselves or others; or to monitor or evaluate a person's mental state.*

15. Mental health service delivery principles

All persons exercising responsibilities under this Act are to have regard to the mental health service delivery principles set out in Schedule 1.

92. Interpretation of Division

In this Division –

prescribed reason, *for applying force to a forensic patient or placing a forensic patient in seclusion or under restraint, means –*

(a) to facilitate the patient's treatment; or

(b) to facilitate the patient's general health care; or

(c) to ensure the patient's health or safety; or

(d) to ensure the safety of other persons; or

(e) to prevent the patient from destroying or damaging property; or

(f) to prevent the patient's escape from lawful custody; or

(g) to provide for the management, good order or security of the SMHU; or

(h) to facilitate the patient's lawful transfer to or from another facility, whether in this State or elsewhere; or

(i) a reason sanctioned by CFP standing orders.

94. Seclusion

(1) Except if authorised under any other law, a forensic patient may be placed in seclusion if, and only if –

(a) the seclusion is authorised as being necessary for a prescribed reason, by –

(i) for a patient who is a child, the CFP; or

(ii) for any other patient, the CFP, a medical practitioner or approved nurse; and

(b) the person authorising the seclusion is satisfied that it is a reasonable intervention in the circumstances; and

(c) the seclusion lasts for no longer than authorised under this section; and

(d) the seclusion is managed in accordance with any relevant CFP standing orders or clinical guidelines.

(2) If a forensic patient is placed in seclusion under this section –

(a) the patient must be clinically observed by a member of the SMHU nursing staff at intervals not exceeding 15 minutes or at such different intervals as CFP standing orders may mandate; and

(b) the patient must be examined by a medical practitioner or approved nurse at intervals not exceeding 4 hours to see if the seclusion should continue or be terminated; and

(c) the patient must also be examined by an approved medical practitioner at intervals not exceeding 12 hours; and

(d) the seclusion must not extend beyond 7 hours unless –

(i) the patient has been examined by a medical practitioner within those 7 hours; and

(ii) the extension is authorised by the CFP within those 7 hours; and

(iii) if applicable, each subsequent extension (regardless of duration) is also authorised in advance by the CFP; and

(e) the CFP may impose conditions on any extension authorised under paragraph (d); and

(f) the CFP, on authorising an initial extension of the seclusion, must stipulate the maximum timeframe for its continuance; and

(g) the patient must be provided with –

(i) suitable clean clothing and bedding; and

(ii) adequate sustenance; and

(iii) adequate toilet and sanitary arrangements; and

(iv) adequate ventilation and light; and

(v) a means of summoning aid; and

(h) the administration of any prescribed medications to the patient must not be unreasonably denied or delayed; and

(i) the patient must not be deprived of physical aids except as may be strictly necessary for the patient's safety or the preservation of those physical aids for the patient's future use; and

(i) the patient must not be deprived of any communication aid that the patient uses in communicating on a daily basis, except as may be strictly necessary for the patient's safety or the preservation of the communication aid for the patient's future use; and

(j) regardless of authorisation, the seclusion must not be maintained to the obvious detriment of the patient's mental or physical health.

(3) To avoid doubt, a forensic patient's seclusion is not taken to have been interrupted or terminated merely by reason of –

(a) a scheduled observation or examination under subsection (2); or

(b) the giving of any necessary treatment or general health care.

(4) Nothing in this section is to be taken as conferring any kind of authority for a forensic patient to be placed in seclusion as a means of punishment or for reasons of administrative or staff convenience.

(5) Notwithstanding the discretionary nature of the power under section 152(1), the CFP must ensure that CFP standing orders are issued for this section.

Note 1 The seclusion of a forensic patient is reviewable by the Tribunal – see Division 2 of Part 3 of Chapter 3.

Note 2 The CFP has power to intervene in such circumstances – see section 147.

96. Records, &c.

(1) This section applies if –

(a) force is applied to a forensic patient otherwise than under any other law; or

(b) a forensic patient is placed in seclusion or under restraint otherwise than under any other law.

(2) The controlling authority is to –

(a) make an appropriate record of the matter; and

(i) give a copy of the record to the patient, together with a statement of rights in a CFP approved form; and

(b) give a copy of the record to the CFP and the Tribunal; and

(c) place a copy of the record on the patient's clinical record.

(3) The CFP or Tribunal, by notice, may require the controlling authority to provide further information about the matter within a required time and the controlling authority is to comply with that requirement.

Schedule 1

1. The mental health service delivery principles are as follows:

(a) to respect, observe and promote the inherent rights, liberty, dignity, autonomy and self-respect of persons with mental illness;

(b) to interfere with or restrict the rights of persons with mental illness in the least restrictive way and to the least extent consistent with the protection of those persons, the protection of the public and the proper delivery of the relevant service;

(c) to provide a service that is comprehensive, accessible, inclusive, equitable and free from stigma;

(d) to be sensitive and responsive to individual needs (whether as to culture, language, age, religion, gender or other factors);

(e) to emphasise and value promotion, prevention and early detection and intervention;

(f) to seek to bring about the best therapeutic outcomes and promote patient recovery;

(g) to provide services that are consistent with patient treatment plans;

(h) to recognise the difficulty, importance and value of the role played by families, and support persons, of persons with mental illness;

(i) to recognise, observe and promote the rights, welfare and safety of the children and other dependants of persons with mental illness;

(j) to promote the ability of persons with mental illness to make their own choices;

(k) to involve persons receiving services, and where appropriate their families and support persons, in decision-making;

(l) to recognise families, and support persons, of persons with mental illness as partners, with mental health service providers, in the provision of their treatment and care to the extent that this is appropriate and consistent with their own wishes;

(m) to respect the wishes of persons receiving services, and the wishes of their families and support persons, to the maximum extent consistent with the health and safety of those persons and the safety of others;

(n) to promote and enable persons with mental illness to live, work and participate in their own community;

(o) to operate so as to raise community awareness and understanding of mental illness and to foster community-wide respect for the inherent rights, liberty, dignity, autonomy and self-respect of persons with mental illness;

(p) to be accountable;

(q) to recognise and be responsive to national and international clinical, technical and human rights trends, developments and advances.