Seclusion

TASMANIA'S MENTAL HEALTH ACT
Rights, Respect, Recovery

Chief Psychiatrist Standing Order 9

Provisions to Which the Order Relates

Mental Health Act 2013 – sections 3, 11, 15, 92, 94, 56, 58 and Schedule 1.

Preamble

1. Seclusion is one of the most restrictive options available to staff in managing the behaviour of patients in approved hospitals and secure mental health units.
2. A patient may only be secluded if the patient is in an approved hospital or approved facility and if the seclusion is authorised as being necessary for a prescribed reason by:
    - For a patient that is a child, the Chief Psychiatrist or a delegate of the Chief Psychiatrist.
    - For any other patients, The Chief Psychiatrist, a delegate of the Chief Psychiatrist, a medical practitioner or an approved nurse.
3. A patient may only be secluded when necessary to:
    a. Facilitate the patient's treatment,
    b. Ensure the patient's health or safety or the safety of other persons, or
    c. To provide for the management, good order or security of the approved hospital or facility in which the patient is being detained.

    In addition to the above, a forensic patient may also be secluded for the following reasons:
    d. To facilitate the patients general health care; or
    e. To prevent the patient from destroying or damaging property; or
    f. To prevent the patient from escaping from lawful custody; or
    g. To provide for the management, good order and security of the secure mental health unit; or
    h. Facilitate the patient's transfer to or from another facility.
4. Patients who are secluded must be observed and examined in accordance with section 56 of the Mental Health Act 2013 for involuntary patients and section 94 of the Mental Health Act 2013 for forensic patients.
5. All patients in seclusion must be provided with suitable clean clothing and bedding, adequate sustenance, adequate toilet and sanitary arrangements, adequate ventilation and light, and a means of summoning aid while in seclusion.

Seclusion

Chief Psychiatrist Standing Order 9

6. The administration of any prescribed medication to a patient who is secluded must not be unreasonably denied or delayed.
7. Patients who are secluded must not be deprived of physical aids, or communication aids that the patient uses in communicating on a daily basis, except as may be strictly necessary for the patient's safety or to preserve the aids for the patient's future use.
8. The person who authorises seclusion is to make an appropriate record of the matter and is to give a copy of the record to the patient, to the Chief Psychiatrist and to the Tasmanian Administrative and Civil Appeals Tribunal-Mental Health Stream (TASCAT)). The person is also to place a copy of the record on the patient's clinical record.
9. The actions referred to in the paragraph above are to be taken as soon as practicable after the seclusion is authorised.

Purpose

This Standing Order directs controlling authorities, medical practitioners, nurses and other approved hospital and secure mental health unit staff members in the seclusion of patients under the *Mental Health Act 2013*, and related matters.

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

Failure by an individual to comply with this Standing Order is not an offence but does constitute proper grounds for instigating professional or occupational disciplinary action against that individual.

Direction

I, Associate Professor Anthony Cidoni being and as the Chief Psychiatrist, pursuant to sections 152 and 153 of the *Mental Health Act 2013* and section 22 of the *Acts Interpretation Act 1931* hereby:

1. Revoke all previous directions (standing orders) issued under section 152 of the *Mental Health Act 2013* with respect to the exercise of responsibilities relating to authorising seclusion with effect from 11:59pm 25 September 2023 and,

2. Issue the following direction (standing order) to controlling authorities (and delegates), authorised persons and other approved hospitals and secure mental health unit staff members exercising responsibilities in relation to authorising seclusion under the *Mental Health Act 2013*, and related matters, with effect from 12:00am on 25 September 2023.

1. The decision to seclude a patient must only be made after less restrictive interventions and de-escalation techniques have been tried without success, or when these have been considered but excluded as inappropriate or unsuitable in the circumstances.

Seclusion

Chief Psychiatrist Standing Order 9

2. Seclusion is only to be authorised to provide for the management, good order or security of an approved hospital or facility when this is necessary to prevent significant damage to property and/or ensure the health and safety of the patient, staff members, other patients, or visitors.
3. Seclusion must never be applied as a means of punishment or to compensate for or overcome inadequate facility design, insufficient numbers of staff or inadequate qualifications or status of staff members on duty at the relevant time.
4. The decision to use seclusion is only to be made following a full risk assessment.
5. The person authorising the seclusion is only to authorise the intervention if he or she has received satisfactory answers to the following questions:
    a. What de-escalation has been implemented?
    b. Has "time out" been attempted?
    c. Has pro re nata (PRN) medication been offered?
    d. Has 1:1 nursing been attempted?
    e. Have other staff who may have rapport with the patient been sourced to attempt de-escalation?
    f. How long is the seclusion expected to last for and what criteria will be used to determine whether the seclusion should be ceased?
    g. What is the post-seclusion plan?
6. Seclusion can be authorised by a medical practitioner or approved nurse for a period not exceeding three (3) hours.
7. The medical practitioner or Approved Nurse authorising seclusion can consult with the Chief Psychiatrist (or Delegate) at any point during the seclusion.
8. The Chief Psychiatrist (or delegate) may impose conditions on the seclusion of the patient at any point during the period of seclusion.
9. A patient is to be secluded only for the period authorised and in no circumstances is the initial period authorised to exceed three (3) hours.
10. A patient who is still in seclusion after three (3) hours must be assessed by a medical practitioner within those three (3) hours to see if the seclusion should continue or be terminated.
11. After conducting a physical examination of the patient, a medical practitioner or approved nurse can authorise the continuation of seclusion if deemed necessary for one specified period not exceeding three (3) hours.
12. Regardless of the Authorisation, the **seclusion must not exceed 6 hours** and must not be maintained to the obvious detriment of the patient's mental or physical health.

Seclusion

Chief Psychiatrist Standing Order 9

13. Any additional period beyond 6 hours is considered a new episode and can only be authorised by the Chief Psychiatrist (or delegate).

14. Full consideration of less restrictive options and performance of a new risk assessment must be completed prior to authorisation being considered.

15. Authorisation is to be obtained at the time that the decision to seclude a patient is made; authorisation must not be given in advance or retrospectively, or conditional upon certain events occurring.

16. Authorisation by Chief Psychiatrist or delegate is only to be given over the phone if:

    a. The person giving the authorisation is satisfied, from the information given to him or her by Medical Practitioner or Approved Nurse present with the patient at the relevant time, that the patient needs to be secluded within the criteria set out in the *Mental Health Act 2013*, and

    b. There is nobody else who could authorise the patient's seclusion in person within a time period that is consistent with the need to apply seclusion.

17. Patients who are secluded must be continually observed by a member of the approved hospital's nursing staff at intervals not exceeding 15 minutes. The focus of the observation must be on the person's safety and dignity and on any change in the person's physical or mental health status.

18. Observation of a patient who is in seclusion must be direct and in person and video monitoring systems or similar technologies may not be relied upon as the sole or dominant means of observation.

19. Children and patients who are otherwise particularly vulnerable must be continually observed; and one-to-one nursing care with respect to patients who are suicidal is mandatory for the entire duration of the seclusion. The use of seclusion for persons who are suicidal is likely to be counter therapeutic and should be used as a last resort.

20. A medical practitioner who examines a patient who is being secluded is only to recommend that the seclusion be continued if the benefits associated with continuing the seclusion are considered to outweigh the detriments and if continuing the seclusion would not be detrimental to the patient's health or safety.

21. Seclusion must be ended immediately as soon as it is no longer considered to be necessary.

22. Suicide gowns (also known as anti-suicide smocks or safety smocks) must not be used on any patient during a period of seclusion.

23. Any use of seclusion must be in accordance with Chief Psychiatrist Clinical Guidelines and with the policies and procedures of the relevant approved hospital or approved facility.

24. Matters relevant to an episode of seclusion must be documented using Chief Psychiatrist Approved Form C09 – Seclusion for involuntary patients or Chief Psychiatrist Approved Form F09 – Seclusion for forensic patients. The form must be completed as soon as practicable after the decision to seclude

Chief Psychiatrist Standing Order 9

the patient is made, and a copy of the Statement of Rights - Seclusion and Restraint is to be provided to the patient.

25. A copy of the completed form must be forwarded to the Chief Psychiatrist by no later than the close of business on the first business day following the day on which the seclusion was authorised.

26. The rationale for seclusion including the outcome of the risk assessment performed prior to the decision to seclude must be clearly documented in the patient's clinical record and discussed with the patient's treating medical practitioner/approved medical practitioner.

27. Incidents leading to the application of seclusion must be logged via the incident management systems in place at the relevant time within the approved hospital or approved facility where the seclusion took place.

28. A monthly report on the use of seclusion within each approved hospital or approved facility is to be provided to the Chief Psychiatrist by no later than 5 working days from the end of each month in which the seclusion took place.

Associate Professor Anthony Cidoni

Chief Psychiatrist

12 September 2023