Seclusion

TASMANIA'S MENTAL HEALTH ACT
Rights, Respect, Recovery

Chief Civil Psychiatrist Standing Order 9

Provisions to Which the Order Relates

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

Preamble

1. Seclusion is one of the most restrictive options available to staff in managing the behaviour of involuntary patients in approved hospitals.
2. An involuntary patient may only be secluded if the patient is in an approved hospital and if the seclusion is authorised by the Chief Civil psychiatrist or a delegate of the Chief Civil Psychiatrist (if the patient is a child), or by the Chief Civil Psychiatrist, a delegate of the Chief Civil Psychiatrist, a medical practitioner or an approved nurse (if the patient is an adult).
3. An involuntary patient may only be secluded when necessary to:
   a. Facilitate the patient's treatment, or
   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 in which the patient is being detained.
4. Patients who are secluded must be observed and examined in accordance with section 56 of the *Mental Health Act 2013* and 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.
5. The administration of any prescribed medication to a patient who is secluded must not be unreasonably denied or delayed.
6. 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.
7. 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 Civil Psychiatrist and to the Mental Health Tribunal. The person is also to place a copy of the record on the patient's clinical record.
8. The actions referred to in paragraph 7 are to be taken as soon as practicable after the seclusion is authorised.

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Purpose

This Standing Order directs controlling authorities, medical practitioners, nurses and other approved hospital staff members in the seclusion of involuntary 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 Order is not an offence but does constitute proper grounds for instituting professional or, as the case may be, occupational disciplinary action against that individual.

Direction

I, Professor Kenneth Clifford Kirkby, being and as the Chief Forensic 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 in relation to authorising seclusion with effect from 11.59 pm on 30 June 2017; and

2. Issue the following direction (standing order) to controlling authorities (and delegates) and authorised persons exercising responsibilities in relation to authorising seclusion under the *Mental Health Act 2013*, and related matters, with effect from 12.00 am on 1 July 2017.

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.
2. Seclusion is only to be authorised to provide for the management, good order or security of an approved hospital 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?

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6. An approved nurse or medical practitioner who authorises a patient's seclusion is to take immediate steps to contact the approved medical practitioner (or delegate of the Chief Civil Psychiatrist) on duty at the relevant time to discuss the seclusion and to seek advice about whether or not the seclusion should be continued, or should cease.
7. An involuntary patient is to be secluded only for the period authorised; and **in no circumstances is the initial period authorised to exceed three (3) hours**.
8. The Chief Civil Psychiatrist or delegate's approval is required for the continuation of seclusion for a period that is longer than thirty **(30)** minutes, if seclusion has been authorised to provide for the management, good order or security of, the relevant approved hospital.
9. Despite the period authorised, a patient's seclusion must not be allowed to continue where this would be to the detriment of the patient's mental or physical health.
10. Each episode of seclusion must be viewed as a new episode with full consideration of less restrictive options and performance of a new risk assessment prior to authorisation being given.
11. 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.
12. Authorisation is only to be given over the phone or via email if:
    a. The person giving the authorisation is satisfied, from the information given to him or her by members of nursing staff present with the patient at the relevant time, that the patient meets the criteria to be secluded within the parameters 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 facilitate the patient's treatment, ensure the patient's health and safety or the safety of others or to maintain order in, and the security of, the approved hospital.
13. 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.
14. Children and patients who are otherwise particularly vulnerable must be continually observed; and consideration must be given to using one-to-one nursing care with respect to patients who are suicidal.
15. An involuntary patient's seclusion may be extended beyond the period authorised if:
    a. The patient has been examined by a medical practitioner immediately prior to the decision to extend the seclusion and the medical practitioner has recommended that the seclusion be extended, and
    b. The period of extension has been authorised by the Chief Civil Psychiatrist or a delegate, in advance.
16. An involuntary patient's seclusion may be extended on more than one occasion; however **in no circumstances is the period of extension to exceed three (3) hours.**

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17. A medical practitioner who examines a patient who is being secluded is only to recommend that the seclusion be continued or extended 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.
18. A patient who is still in seclusion after twelve **(12)** hours must have been examined by an approved medical practitioner within that twelve **(12)** hour period.
19. Seclusion must be ended immediately as soon as it is no longer considered to be necessary.
20. Suicide gowns (also known as anti-suicide smocks or safety smocks) must not be used on any patient during a period of seclusion.
21. Any use of seclusion must be in accordance with Chief Civil Psychiatrist Clinical Guidelines and with the policies and procedures of the relevant approved hospital.
22. Matters relevant to an episode of seclusion must be documented using Chief Civil Psychiatrist Approved Form 9: Seclusion. The form must be completed as soon as practicable after the decision to seclude the patient is made.
23. A copy of the completed form must be forwarded to the Chief Civil Psychiatrist by no later than the close of business on the first business day following the day on which the seclusion was authorised.
24. 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.
25. 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.
26. A monthly report on the use of seclusion within approved hospitals is to be provided to the Chief Civil Psychiatrist by no later than the 20th day of the month after the month in which the seclusion was used.

Professor Kenneth Clifford Kirkby

Chief Civil Psychiatrist

Date: 1 July 2017