Seclusion

Chief Forensic Psychiatrist Standing Order 9

Provisions to Which the Order Relates

Mental Health Act 2013 – sections 3, 11, 15, 92, 94, 96 and Schedule 1.

Preamble

1. Seclusion is one of the most restrictive options available to staff in managing the behaviour of forensic patients in secure mental health units.
2. A forensic patient may only be secluded if the seclusion is authorised by the Chief Forensic Psychiatrist or a delegate of the Chief Forensic Psychiatrist, if the patient is child, or by the Chief Forensic Psychiatrist or a delegate of the Chief Forensic Psychiatrist, a medical practitioner or approved an nurse if the patient is an adult.
3. A forensic patient may only be secluded when necessary to:
   a. Facilitate the patient's treatment or general health care
   b. Ensure the patient's health or safety or the safety of other persons, or
   c. Prevent the patient from destroying or damaging property
   d. Prevent the patient from escaping from the custody of the controlling authority of the secure mental health unit or another person who has the custody of the forensic patient under an order of a court
   e. Maintain order in, and the security of, the secure mental health unit
   f. Facilitate the patient's transfer to or from another facility
4. Patients who are secluded must be observed and examined in accordance with section 94 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 Forensic 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 secure mental health unit staff members in the seclusion of forensic 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 have regard to this Standing Order 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 instigating professional or 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:

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 the seclusion of forensic patients with effect from 11.59 pm on 30 June 2017; and

Issue the following direction (standing order) 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:

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 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.
3. The decision to use seclusion is only to be made following a full risk assessment.
4. 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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5. 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 Forensic 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.
6. 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**.
7. The Chief Forensic 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 prevent the patient from escaping the lawful custody of the controlling authority of the secure mental health unit or another person who has the custody of the forensic patient under an order of a court, or to maintain order in, and the security of, the secure mental health unit.
8. 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.
9. 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.
10. 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.
11. 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 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.
12. 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.
13. 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.
14. A forensic 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 Forensic Psychiatrist or a delegate, in advance.

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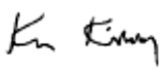
15. A forensic patient's seclusion may be extended on more than one occasion; however **in no circumstances is the period of extension to exceed three (3) hours.**
16. A medical practitioner who examines a patient who is being secluded is only to recommend that the seclusion be continued or extended 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.
17. 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.
18. Seclusion must be ended immediately as soon as it is no longer considered to be necessary.
19. Suicide gowns (also known as anti-suicide smocks or safety smocks) must not be used on any patient during a period of seclusion.
20. Any use of seclusion must be in accordance with Chief Forensic Psychiatrist Clinical Guidelines and with the policies and procedures of the relevant secure mental health unit.
21. Matters relevant to an episode of seclusion must be documented using Chief Forensic Psychiatrist Approved Form 9: Seclusion. The form must be completed as soon as practicable after the decision to seclude the patient is made.
22. A copy of the completed form must be forwarded to the Chief Forensic Psychiatrist by no later than the close of business on the first business day following the day on which the seclusion was authorised.
23. 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.
24. Incidents leading to the application of seclusion must be logged via the incident management systems in place at the relevant time within the secure mental health unit.
25. A monthly report on the use of seclusion within secure mental health units is to be provided to the Chief Forensic 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 Forensic Psychiatrist

Date: 1 July 2017