

Australian Capital Territory

# Mental Health (Use of Seclusion) Guidelines 2022 (No 1)

Notifiable instrument NI2022–603

made under the

**Mental Health Act 2015, s 198A (Chief psychiatrist may make guidelines)**

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## **1 Name of instrument**

This instrument is the *Mental Health (Use of Seclusion) Guidelines 2022 (No 1)*\*

## **2 Commencement**

This instrument commences on the day after it is notified.

## **3 Direction**

I make the attached Use of Seclusion Guideline to set requirements for the use of seclusion.

Dr Dinesh Arya  
Chief Psychiatrist  
22 November 2022

\*Name amended under Legislation Act, s 60

# CHIEF PSYCHIATRIST GUIDELINE

## Use of involuntary seclusion

PURPOSE	To ensure consistency and compliance in the use of involuntary seclusion.
COMPLIANCE STATEMENT	<p>The legal basis for the use of involuntary seclusion must be clear.</p> <p>The use of involuntary seclusion must not severely, adversely affect a person in a manner and to a degree incompatible with the international human rights protection against torture and cruel, inhumane and degrading treatment. In assessing whether the person has been so affected, regard must be had to their particular personality and ‘vulnerability and their inability to complain coherently, or at all, about how they are being affected by any particular treatment’. (<i>Hurtado v. Switzerland [1994] - as cited in Mental Health Bill 2015 Explanatory Statement</i>)</p> <p>The use of involuntary seclusion must be a <b>last resort</b> option to prevent serious and imminent harm to a person, another person or property. It must take account of the following:</p> <ul style="list-style-type: none"> <li>• Persons receive assessment and treatment, care or support that is recovery-orientated and provided in a way that is least restrictive.</li> <li>• involuntary seclusion should only be used if the treating clinicians are satisfied that it is the only way in the circumstances to prevent the person from causing harm to themselves, someone else or property.</li> <li>• If a person is subjected to involuntary seclusion, the person must be examined by a relevant doctor of the relevant health facility at least once in each 4-hour period for which the person is in involuntary seclusion.</li> <li>• If a person is subject to involuntary seclusion, the person’s clinical record must include documentation of the fact that the person is subject to involuntary seclusion and the reasons for the involuntary seclusion.</li> <li>• The Public Advocate must be informed in writing of the involuntary seclusion.</li> <li>• A register of involuntary seclusion must be maintained.</li> <li>• A person should be advised of their rights of review.</li> </ul>

SCOPE	<ul style="list-style-type: none"> <li>• This guideline applies to support, care and treatment provided in an approved mental health facility.</li> <li>• Any breaches of this guideline must be reported to the Chief Psychiatrist.</li> <li>• Health service providers must include reference to this guideline in their local policies and procedures related to the use of involuntary seclusion. They must ensure that it is communicated to staff and that training is provided to make sure practices are consistent with this guideline.</li> <li>• This guideline provides guidance to clinicians, and it is agreed that it should not limit police functions. Therefore, this guideline does not apply to Police exercising a function under the Mental Health Act 2015.</li> </ul>
DEFINITIONS	<p><b>Chief Psychiatrist</b> is a psychiatrist and public servant appointed by the Minister. Functions of the Chief Psychiatrist include provision of treatment, care or support, rehabilitation and protection for persons who have a mental illness.</p> <p><b>Involuntary seclusion</b> is the involuntary confinement of a patient at any time of day or night alone in a room or area from which free exit is prevented.</p> <p><b>Relevant doctor</b> means a person employed at the ‘relevant place’ as a consultant psychiatrist, psychiatric registrar in consultation with a consultant psychiatrist or another doctor in consultation with a consultant psychiatrist.</p> <p><b>Relevant health facility</b> means an approved mental health facility or community care facility.</p> <p><b>The Person in Charge</b> is a senior member of staff in charge of an approved mental health facility at any particular time. This is generally the Clinical Director, Assistant Director of Nursing (ADON), Clinical Nurse Consultant (CNC) or their delegate (after hours).</p>
DETAILED DESCRIPTION	<p><b>Reduction and elimination of restrictive practices</b></p> <p>There is a commitment to reducing and where possible eliminating interventions that are considered restrictive. Use of these interventions (including the use of restraint) should be used as a last resort after a consideration of other less restrictive alternatives to prevent imminent harm to the person, others or to property.</p> <p><b>Care must be Trauma-informed</b></p> <p>The experience of being restrained can be traumatic, including for those who have a history of trauma. Care must always be</p>

	<p>trauma-informed.</p> <p><b>Rooms designated for use of involuntary seclusion</b></p> <p>Only rooms that have been approved for use for involuntary seclusion may be used for seclusion.</p> <p><b>Authorisation of involuntary seclusion</b></p> <p>Use of involuntary seclusion is a clinical decision and must be authorised by the responsible Consultant Psychiatrist, who has assessed the person immediately prior to authorising the involuntary seclusion, or by the covering/on-call Consultant Psychiatrist.</p> <p>If a Consultant Psychiatrist is not immediately available to assess the person and the person is in immediate danger of harming themselves or somebody else, the Person in Charge may authorise involuntary seclusion. However, as soon as it is safe to do so, the person in charge must seek authorisation for the involuntary seclusion from the Consultant Psychiatrist.</p> <p><b>Observations and care during involuntary seclusion</b></p> <p>A person who is in involuntary seclusion must be under constant visual observation. An essential consideration remains throughout the involuntary seclusion period that the person's needs are continuing to be met, and their dignity is protected by the provision of appropriate facilities and supplies.</p> <p><b>Review</b></p> <p>Involuntary seclusion should only ever be authorised for the minimum period of time necessary, and a maximum of four hours at a time.</p> <p>The person must undergo a physical and mental health assessment every four hours by a medical officer.</p> <p><b>Follow up on termination of involuntary seclusion</b></p> <p>When the person is settled, the treating team should offer them the opportunity for debriefing and provide psychological support following involuntary seclusion. This should include the person's understanding and experience of the incident; an explanation of the reason(s) involuntary seclusion had to be used; whether the use of involuntary seclusion was considered among other less restrictive alternatives; and other less restrictive interventions that may be helpful in the future.</p>
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	<p>The person should be given a choice as to who they would like to discuss their experience with, wherever possible, and whether they would like to have a support person such as a guardian, patient advocate or carer present.</p> <p><b>Clinical team debriefing</b></p> <p>The clinical team involved in the use of involuntary seclusion must have debriefing to consider why the use of involuntary seclusion was needed, a discussion of any other less restrictive alternatives that could have been used in the circumstances, the experience of staff involved, outcomes and any learnings.</p> <p><b>Documentation</b></p> <p>The following documentation must be completed in relation to above intervention:</p> <ul style="list-style-type: none"> <li>• The person’s clinical record must include documentation of the fact of, and the reasons for the use of involuntary seclusion and the duration of the involuntary seclusion used;</li> <li>• Whether a clinical debriefing in relation to the use of involuntary seclusion took place;</li> <li>• The public advocate must be notified in writing.</li> </ul> <p><b>Reduction and Elimination Plans</b></p> <p>A person whose behaviour is repeatedly considered to be threatening to themselves or others and whose symptoms fail to respond to a full range of clinical interventions must be reviewed to explore other less restrictive strategies as an alternative to involuntary seclusion.</p>
IMPLEMENTATION	<p>Services will disseminate this Guideline to all staff.</p> <p>A service-specific policy or procedure may be developed in line with this Chief Psychiatrist’s Guideline.</p> <p>A guideline comes into effect once notified on the ACT Legislation Register.</p>

RECORDS MANAGEMENT	<p>All records are managed in accordance with the <i>Health Records (Privacy &amp; Access) Act 1997 (ACT) Territory Records Act 2002</i> and ACT Health Directorate policy and procedures.</p> <p>All guidelines will be published on the <a href="https://www.act.gov.au/office-of-the-chief-psychiatrist">Office of the Chief Psychiatrist   Health (act.gov.au)</a> website.</p> <p>All guidelines are notifiable instrument and are available on the ACT Legislation Register at <a href="https://www.legislation.act.gov.au">ACT Legislation Register</a>.</p>
RELATED LEGISLATION	<p><i>Mental Health Act 2015</i></p> <p><i>Mental Health (Secure Facilities) Act 2016</i></p> <p><i>Children and Young People Act 2008</i></p> <p><i>Human Rights Act 2004</i></p> <p><i>Legislation Act 2011</i></p> <p><i>Public Advocate Act 2005</i></p> <p><i>Work Health and Safety Act 2011</i></p> <p><i>Carers Recognition Act 2021</i></p>
SUPPORTING DOCUMENTS	<p><a href="#"><u><i>Australian Institute of Health and Welfare Data Dictionary 2015.</i></u></a></p>