5 Seclusion in Australian and New Zealand Mental Health Acts

	ACT: **Mental Health Act 2015** ss65, 73, 80-83, 107, 144A, 263-4, 266	NSW: **Mental Health Act 2007** ss3, 68, 190; Health Policy Directive 2012/35	NT: **Mental Health and Related Services Act 1998** ss3, 61	QLD: **Mental Health Act 2016** ss5, 253-261, 263	SA: **Mental Health Act 2009 ss7, 34A**	TAS: **Mental Health Act 2013** ss12, 56	VIC: **Mental Health Act 2014** ss10, 105-112	WA: **Mental Health Act 2014** ss5, 211-225	NZ: **Mental Health (Compulsory Treatment and Assessment) Act 1992** s71, Regulation NZS 8134.3
Definition of 'seclusion'	N/A	Confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented.	Confinement of the patient at any time of the day or night alone in a room or area from which free exit is prevented.	Confinement of the patient at any time of the day or night alone in a room or area from which free exit is prevented.	Confinement of a person, alone in a room or area from which cannot leave of own volition	Deliberate confinement of an involuntary patient or forensic patient, alone, in a room or area that the patient cannot freely exit.	Sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave.	Confinement of a person being provided with treatment/care at an authorised hospital by leaving the person at any time of the day or night alone in a room/ area from which it is not within the person's control to leave.	Where a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit.
When may seclusion be used?	If it is the only way in the circumstances to prevent the person from causing harm to themselves or someone else. In emergencies, seclusion may be necessary to safely apprehend a person and remove them to an approved mental health facility (AHMF).	To manage the risk of serious imminent harm only when appropriate, safe alternative options have been considered and trialled. Use the minimum necessary force for the briefest period required in the circumstances.	If no other less restrictive method of control is suitable and it is necessary to provide medical treatment, or to prevent harm to the patient/ others, persistent destruction of property, or absconding.	If there is no other reasonably practical way to protect the patient or others from physical harm. Seclusion must also comply with any reduction and elimination plan.	Only as a last resort for safety reasons, but seclusion is available to ensure treatment and compliance with the Act, and to prevent nuisance or harm to others.	To facilitate the patient's treatment, or to ensure their safety or that of others, or to provide for the management, good order or security of an approved hospital.	If necessary to prevent imminent and serious harm to the person or to another person, and after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable.	If necessary to prevent the person physically injuring him/herself or another, or persistently causing damage to property, and there is no less restrictive means available to prevent this.	If necessary for the care or treatment of the patient, or the protection of other patients.
Where can seclusion be used?	Approved community care facility, an AMHF, or while apprehending a person and taking them to an AMHF.	Mental health facility.	Approved treatment facility.	Authorised mental health service.	No general restrictions listed. If subject to an Inpatient Treatment Order – a treatment centre.	Approved hospital.	Designated Mental Health Service.	Authorised hospital.	Premises designated for the purpose by or with the approval of the Director of Area Mental Health Services.
Who may authorise seclusion?	Chief Psychiatrist (CP) or a community care coordinator. In emergencies, a police officer, authorised ambulance paramedic, doctor or mental health officer apprehending the person and taking them to an AMHF.	Medical superintendent or a medical officer authorised by one (often the senior nurse who leads the response team).	Authorised psychiatric practitioner; or (in an emergency) by the senior registered nurse on duty.	Authorised doctor, or a health practitioner authorised by one.*	Treatment centre staff.	Chief Civil Psychiatrist (CCP), medical practitioner or approved nurse; if a child, only the CCP.	Authorised psychiatrist, registered medical practitioner or the senior registered nurse on duty.	Medical practitioner or, in an emergency, a mental health practitioner.	Responsible clinician or, in an emergency, a nurse or other health professional.
Who else may vary/ revoke the authorisation?	N/A	Medical superintendent, operational nurse manager, senior nurse, or medical officer – preferably a psychiatrist.	Authorised psychiatric practitioner.	Chief psychiatrist or authorised doctor. The authorisation may also allow a health practitioner to end the seclusion.	N/A	CCP, medical practitioner or approved nurse.	Authorised psychiatrist or (if one is not reasonably available) a registered medical practitioner.	Medical practitioner or mental health practitioner or the person in charge of a ward at an authorised hospital.	Responsible clinician.
Who must be notified?	Public Advocate.	Primary carer. If none exists, a family member must be contacted (taking the patient's wishes into account in this matter).	Authorised psychiatric practitioner and an adult guardian or decision maker if the patient has one.	Chief Psychiatrist (if patient has been or will be secluded for over 9 hours in a 24 hour period).	N/A	N/A	Authorised psychiatrist and the Chief Psychiatrist. Also, a parent, nominated person, or guardian.	Medical practitioner and – if there is one, and they did not authorise the seclusion themselves – the treating psychiatrist.	Responsible clinician.
How long can seclusion last?	Minimum period necessary. The CP must ensure an examination by a consultant psychiatrist (or a doctor in consultation with one) at least every four hours.	No express limit. In prolonged cases, comprehensive assessment must be carried out every 24–48 hours, preferably with the carer attending.	Minimum period necessary.	Three hours, and no more than nine hours in a 24 hour period unless a reduction and elimination plan has been made. A single 12 hour extension is lawful.	Minimum period necessary.	Seven hours. Extensions may be authorised by the CCP if the patient has been examined by a medical practitioner.	Until it is no longer necessary to prevent imminent and serious harm to the person or to another person.	Two hours. Extensions may be made if a medical practitioner examines the patient in that period.	Minimum period necessary; note that the patient has a right to the company of others.

Disclaimer: These tables have been developed by the RANZCP as at 30 June 2017 in order to allow key provisions in the mental health Acts to be compared. They are intended for reference purposes only and are not intended to be a substitute for legal or clinical advice.

Comment: The NSW Act has the narrowest grounds for authorising seclusion: 'to manage the risk of serious imminent harm only when appropriate, safe alternative options have been considered and trialled.' Other Acts also authorise seclusion on other grounds such as absconding, persistently destroying property and facilitating treatment. The SA Act has the widest grounds, although it is accompanied by a non-mandatory guideline that narrows them considerably. The Acts also vary substantially in respect to who may authorise seclusion, who must be notified, and the length of time seclusion can be applied. *The Qld Act also refers to 'emergency seclusion', which may be authorised for one hour by a health practitioner if there is no other reasonably practicable way to protect the patient or others from physical harm. An authorised doctor must be notified as soon as practicable.

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