CHIEF FORENSIC PSYCHIATRIST APPROVED FORM 10

TASMANIA'S MENTAL HEALTH ACT
Rights, Respect, Recovery

RESTRAINT (FORENSIC)

Mental Health Act 2013
Sections 92, 95-96

THCI: (Patient Id):

Family Name: _____ Given Name:_____

DOB: _____/_____/_____ Gender: M ☐ F☐ TG/IT ☐

Address:_____

Phone: _____ Mobile: _____

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PART A: AUTHORISATION OF RESTRAINT

CHIEF FORENSIC PSYCHIATRIST / DELEGATE / MEDICAL PRACTITIONER / APPROVED NURSE TO COMPLETE

The Chief Forensic Psychiatrist (CFP) (or a delegate), a medical practitioner or an approved nurse may authorise an adult's physical restraint.

Only the CFP or a delegate may authorise chemical or mechanical restraint, or the physical restraint of a child.

Chemical restraint means medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition.

Mechanical restraint means a device that controls a person's freedom of movement.

Physical restraint means bodily force that controls a person's freedom of movement.

A forensic patient may be placed under restraint if, and only if:

The restraint is authorised as being necessary to:

- *Facilitate the patient's treatment, or*
- *Facilitate the patient's general health care, or*
- *Ensure the patient's health or safety, or*
- *Prevent the patient from destroying or damaging property, or*
- *Prevent the patient's escape from lawful custody, or*
- *Provide for the management, good order or security of the secure mental health unit, or*
- *Facilitate the patient's lawful transfer to or from another facility, whether in Tasmania or elsewhere, and*

The person authorising the restraint is satisfied that the restraint is a reasonable intervention in the circumstances, and

The restraint lasts for no longer than authorised, and

The means of restraint employed in the specific case is, in the case of mechanical restraint, approved in advance by the CFP or a delegate, and

The restraint is managed in accordance with Chief Forensic Psychiatrist Standing Orders and Clinical Guidelines.

A patient may not be placed under restraint as a means of punishment or for reasons of administrative or staff convenience.

*In the case of chemical restraint, or mechanical restraint to transport the patient from one approved facility to another, **the period authorised may not exceed seven (7) hrs.***

*In all other cases, **the period authorised may not exceed three (3) hrs.***

These periods may be extended – see Parts C and D.

Patient's name: _____

Name/Identity Card/Payroll Number of person authorising restraint:

_____

Status of person authorising restraint:

☐ CFP or delegate ☐ Medical Practitioner ☐ Approved nurse

Form of restraint authorised:

☐ Chemical. Medication type/dosage: _____

☐ Mechanical. Means of restraint: _____

☐ Physical: _____

I **am satisfied** that it is necessary to restrain the patient named above (*tick all that apply*):

- ☐ To facilitate the patient's treatment
- ☐ To ensure the patient's health or safety
- ☐ To ensure the safety of other persons
- ☐ To facilitate the patient's general health care
- ☐ To prevent the patient from destroying or damaging property
- ☐ To prevent the patient's escape from lawful custody
- ☐ To provide for the management, good order or security of the secure mental health unit
- ☐ To facilitate the patient's lawful transfer to or from another facility

I am satisfied that the restraint is a reasonable intervention in the circumstances for the following reasons:

_____

_____

I hereby authorise restraint for a period of: _____ Hours and _____ Minutes

commencing on Date: / / at Time: _____:_____(24 hr)

Date and time of authorisation: Date: / / Time: _____:_____ (24 hr)

Is the person authorising restraint completing this form?

☐ **Yes – person to sign here:** _____

☐ **No – members of nursing/medical staff to complete:**

We confirm that the person named above has authorised restraint for the patient named above, for the reasons given above:

Dr/Nurse Name/Payroll/ID Number 1: _____ Signature: _____

Dr/Nurse Name/Payroll/ID Number 1: _____ Signature: _____

COPY TO: ☐ Patient ☐ CFP (if authorised by a delegate, medical practitioner or nurse) ☐ Tribunal ☐LOC ☐ If patient is a child or if there is consent - patient's parent/support person/representative **OTHER:** ☐ Statement of rights to patient ☐ Explanation to patient in language and form that the patient can understand

CONTACT DETAILS: **MHT:** Phone: (03) 6165 7491 Email: mht.applications@justice.tas.gov.au
CFP: Phone: (03) 6166 0781 Email: chief.psychiatrist@dhhs.tas.gov.au

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PART B: CLINICAL/MEDICAL OBSERVATIONS

MEMBER OF NURSING STAFF / MEDICAL PRACTITIONER / APPROVED MEDICAL PRACTITIONER TO COMPLETE

Patient's name: _____

Date/time restraint commenced: Date: / / Time: ____:____(24 hr)

Date/time restraint ceased: Date: / / Time: ____:____(24 hr)

A patient who has been placed under restraint must be clinically observed by a member of the secure mental health unit's nursing staff at intervals not exceeding 15 minutes or at such different intervals as standing orders may mandate.

A patient who has been placed under restraint must be examined by a medical practitioner or approved nurse at intervals not exceeding four (4) hours to see if the restraint should continue or be terminated.

A patient who has been placed under restraint must also be examined by an approved medical practitioner at intervals not exceeding 12 hours.

Regardless of authorisation, restraint must not be maintained to the obvious detriment of the patient's mental or physical health.

The shaded rows are a reminder for a medical practitioner or approved nurse that the patient must be examined at intervals not exceeding four (4) hours.

Date of observation/ examination	Time of observation/ examination (24 hours)	Comments/Observations	Name/Identity Card/Payroll Number & Status	
			Name/ Identity Card/Payroll Number	Status (Nurse/ MP/AMP)
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COPY TO: ☐ CFP ☐ LOC

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PART C: EXTENSION OF RESTRAINT - INITIAL

CHIEF FORENSIC PSYCHIATRIST / DELEGATE TO COMPLETE

Patient's name: _____

Date and time restraint first commenced: Date: / / at Time: ____:____(24 hr)

Date and time restraint will cease, if not extended: Date: / / at Time: ____:____(24 hr)

A period of restraint may be extended.

The period of extension must be authorised in advance by the CFP or a delegate and authorisation may only be given if the patient has been examined by a medical practitioner immediately prior to the decision to extend the patient's restraint.

A forensic patient's restraint may be extended more than once.

In the case of chemical restraint, or mechanical restraint to transport the patient from one approved facility to another, ***the period of extension may not exceed seven (7) hrs.***

In all other cases, ***the period of extension may not exceed three (3) hrs.***

The CFP (or delegate) may impose conditions on any extension and must stipulate the maximum timeframe for the restraint's continuance.

Name of Chief Forensic Psychiatrist/delegate authorising the extension of restraint:

_____

I **confirm** that the patient named above was examined by *(insert name of medical practitioner)* _____ on Date: / / on Time: ____:____ (24 hr) and **hereby extend** the period for which the patient named above may be restrained for an additional period of _____ Hours and _____ Minutes.

Unless subsequently extended or sooner ceased, the patient's restraint is to cease on:

Date: / / Time: _____:_____ (24 hr)

Conditions imposed on extension *(if applicable)*:

_____

_____

Date and time of extension: Date: / / Time: _____:_____ (24 hr)

Is the person extending the restraint completing this form?

☐ **Yes – CFP/delegate to sign here:** _____

☐ **No – members of nursing/medical staff to complete:**

We confirm that the CFP/delegate named above has authorised an extension of the period for which the patient named above may be restrained, for the period referred to above, subject to the conditions (if any) specified above:

Dr/Nurse Name/Payroll/ID Number 1: _____ Signature: _____

Dr/Nurse Name/Payroll/ID Number 1: _____ Signature: _____

COPY TO: ☐Patient ☐ CFP (if authorised by a delegate) ☐ Tribunal ☐ LOC ☐ If patient is a child or if there is consent - patient's parent/support person/representative **OTHER:**☐Statement of rights to patient ☐ Explanation to patient in language and form that patient can understand

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PART D: EXTENSION OF RESTRAINT – SUBSEQUENT

CHIEF FORENSIC PSYCHIATRIST / DELEGATE TO COMPLETE

Patient's name: _____

Date/time restraint first commenced: Date: / / Time: ____:____(24 hr)

Date/time restraint extended: Date: / / Time: ____:____(24 hr)

Date/time restraint will cease, if not subsequently extended: Date: / / Time: ____:____(24 hr)

A period of restraint that has already been extended may be further extended.

The further period of extension must be authorised in advance by the CFP or a delegate and authorisation may only be given if the patient has been examined by a medical practitioner immediately prior to the decision to further extend the patient's restraint.

A forensic patient's restraint may be extended more than once.

In the case of chemical restraint, or mechanical restraint to transport the patient from one approved facility to another, ***the period of extension may not exceed seven (7) hrs.***

In all other cases, ***the period of extension may not exceed three (3) hrs.***

The CFP (or delegate) may impose conditions on any extension and must stipulate the maximum timeframe for the restraint's continuance.

Name of Chief Forensic Psychiatrist or delegate authorising the subsequent extension of restraint:

_____

I confirm that the patient named above was examined by *(insert name of medical practitioner)*

_____ on Date: / / and Time: ____:____ (24 hr)

and **hereby further extend** the period for which the patient named above may be restrained

for an additional period of _____ Hours and _____ Minutes.

Unless subsequently extended or sooner ceased, the patient's restraint is to cease on:

Date: / / Time: _____:_____ (24 hrs)

Conditions imposed on extension *(if applicable)*:

_____

_____

Date and time of extension: Date: / / Time: _____:_____ (24 hrs)

Is the person extending the restraint completing this form?

☐ **Yes – CFP/delegate to sign here:** _____

☐ **No – members of nursing/medical staff to complete:**

We confirm that the CFP/delegate named above has authorised an extension of the period for which the patient named above may be restrained, for the period referred to above, subject to the conditions (if any) specified above:

Dr/Nurse Name/Payroll/ID Number 1: _____ Signature: _____

Dr/Nurse Name/Payroll/ID Number 1: _____ Signature: _____

COPY TO: ☐ Patient ☐ CFP (if authorised by a delegate) ☐ Tribunal ☐ LOC ☐ If patient is a child or if there is consent - patient's parent/support person/representative **OTHER:** ☐ Statement of rights to patient ☐ Explanation to patient in language and form that patient can understand

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