CHIEF FORENSIC PSYCHIATRIST APPROVED FORM 9

TASMANIA'S MENTAL HEALTH ACT
Rights, Respect, Recovery

SECLUSION (FORENSIC)

Mental Health Act 2013
Sections 94, 96

THCI: (Patient Id):

Family Name: _____ Given Name:_____

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

Address:_____

Phone: _____ Mobile: _____

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FT2131555X

PART A: AUTHORISATION OF SECLUSION

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 patient's seclusion.

Only the CFP (or a delegate) may authorise a child patient's seclusion.

Seclusion means the deliberate confinement of a forensic patient, alone, in a room or area that the patient cannot freely exit.

A forensic patient may be placed in seclusion if, and only if:

The seclusion is authorised as being necessary for:

- *Patient's treatment, and*
- *Patient's general health care, and*
- *Patient's health or safety, and*
- *Prevention of the patient from destroying or damaging property, or*
- *Prevention of the patient's escape from lawful custody, and*
- *Management of the good order or security of the secure mental health unit, or*
- *Patient's lawful transfer to or from another facility, whether in Tasmania or elsewhere, or*
- *Reason(s) sanctioned by standing orders, and*

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

The seclusion lasts for no longer than authorised, and

The seclusion is managed in accordance with any relevant standing orders or clinical guidelines.

*Seclusion may be authorised for a period of **up to three (3) hrs.** This period may be extended – see Parts C and D of this form.*

Patient's name: _____

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

_____

Status of person authorising seclusion:

☐ Chief Forensic Psychiatrist or delegate ☐ Medical Practitioner ☐ Approved nurse

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

- ☐ Facilitate treatment
- ☐ Facilitate general health care
- ☐ To ensure the patient's health and/or safety
- ☐ To protect the safety of other persons
- ☐ 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 SMHU
- ☐ To facilitate the patient's lawful transfer to or from another facility, whether in Tasmania or elsewhere

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

_____

_____

I hereby authorise seclusion for a period of _____ Hours and _____ Minutes

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

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

Is the person authorising seclusion completing this form?

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

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

We confirm that the person named above has authorised seclusion 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 - copy to parent/support person/representative **OTHER:** ☐ Statement of rights to patient ☐ Explanation to patient in language and form that patient can understand

CONTACT DETAILS: MHT: (03) 6165 7491 mht.applications@justice.tas.gov.au **CFP:** (03) 6166 0781 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 seclusion commenced: Date: / / Time: ____:____(24 hrs)

Date/time seclusion ceased: Date: / / Time: ____:____(24 hrs)

A patient in seclusion 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 in seclusion must be examined by a medical practitioner or approved nurse at intervals not exceeding four (4) hours to see if the seclusion should continue or be terminated.

A patient in seclusion must also be examined by an approved medical practitioner (AMP) at intervals not exceeding 12 hours.

A patient's seclusion is not taken to have been interrupted or terminated merely by reason of scheduled observations or examination or by the giving of any necessary treatment or general health care.

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 hrs)	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

CONTACT DETAILS: CFP: Phone: (03) 6166 0781 Email: chief.psychiatrist@dhhs.tas.gov.au

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PART C: EXTENSION OF SECLUSION - INITIAL

CHIEF FORENSIC PSYCHIATRIST / DELEGATE TO COMPLETE

Patient's name: _____

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

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

A period of seclusion may be extended.

The period of extension must be authorised by the CFP or 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 seclusion.

*A forensic patient's seclusion may be extended more than once; however **in no circumstances is the period of extension to exceed three (3) hrs.***

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

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

_____

I **confirm** that the patient named above was examined by *(insert name of medical practitioner)* _____ on Date: / / and Time: ____:____ (24 hr)

and **hereby extend** the period for which the patient named above may be secluded for an additional period of _____ Hours and _____ Minutes.

Unless subsequently extended or sooner ceased, the patient's seclusion 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 seclusion 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 secluded, 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 delegate) ☐ Tribunal ☐ LOC ☐ If patient is a child or if there is consent - copy to 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 SECLUSION – SUBSEQUENT

CHIEF FORENSIC PSYCHIATRIST / DELEGATE TO COMPLETE

Patient's name: _____

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

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

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

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

The further period of extension must be authorised 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 seclusion.

*A forensic patient's seclusion may be extended more than once; however **in no circumstances is the period of extension to exceed three (3) hrs.***

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

Name of Chief Forensic Psychiatrist/delegate authorising the subsequent extension of seclusion:

_____

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

_____ on Date: / / and Time: ____:____ (24 hr)I and **hereby extend** the period for which the patient named above may be secluded for an additional period of _____ Hours and _____ Minutes.

Unless subsequently extended or sooner ceased, the patient's seclusion 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 seclusion 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 a subsequent extension of the period for which the patient named above may be secluded, 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 delegate) ☐ Tribunal ☐ LOC **OTHER:** ☐ Statement of rights to patient ☐ Explanation to patient in language and form that patient can understand ☐If patient is a child or if there is consent - copy to parent/support person/representative

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