CHIEF CIVIL PSYCHIATRIST APPROVED FORM 10

RESTRAINT (INVOLUNTARY)

Mental Health Act 2013
Sections 57 - 58

TCHI (Patient ID): ____________________________
Family Name: ____________________________
Given Names: ____________________________
Date of Birth: __ / __ / __ Gender: ☐ M ☐ F ☐ TG / IT
Address: ____________________________
Telephone: __________ Mobile: __________

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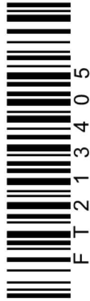

PART A: AUTHORISATION OF RESTRAINT

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

The Chief Civil Psychiatrist (CCP) (or a delegate), a medical practitioner or an approved nurse may authorise physical restraint of an adult.

Only the CCP 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.

An involuntary patient may be placed under restraint if, and only if:

- *The patient is in an approved hospital or approved assessment centre, and*
- *The restraint is authorised as being necessary to:*
  - *Facilitate the patient's treatment, or*
  - *Ensure the patient's health or safety, or*
  - *Ensure the safety of other persons, or*
  - *Effect the patient's transfer to another facility, whether in Tasmania or elsewhere, and*
- *The person authorising the restraint is satisfied that it 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 a mechanical restraint, approved in advance by the CCP or a delegate, and*
- *The restraint is managed in accordance with Chief Civil 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: ____________________________

Approved facility in which patient is being detained/assessed:

☐ NWRH (Burnie) ☐ LGH ☐ RHH ☐ Roy Fagan Centre ☐ Millbrook Rise Centre

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

____

Status of person authorising restraint:

☐ Chief Civil Psychiatrist or a 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 effect the patient's transfer to 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:

1. Dr/Nurse Name/Payroll/ID Number 1: _____________

Signature: ____________________________

Dr/Nurse Name/Payroll/ID Number 2: _____________

Signature: ____________________________

COPY TO: ☐ Patient ☐ CCP (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 patient can understand

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

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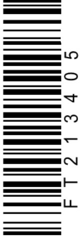

PART B: CLINICAL/MEDICAL OBSERVATIONS

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

Patient's name: ____

Approved hospital OR assessment centre in which patient is being detained/assessed:

☐ NWRH (Burnie) ☐ LGH ☐ RHH ☐ Roy Fagan Centre ☐ Millbrook Rise Centre

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 approved hospital'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 hr)	Comments/Observations	Name/Identity Card/Payroll Number & Status	
			Name/ Identity Card/Payroll Number	Status (Nurse/ MP / AMP)
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COPY TO: ☐ CCP ☐ LOC

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

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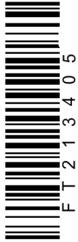

PART C: EXTENSION OF RESTRAINT – INITIAL

CHIEF CIVIL PSYCHIATRIST / DELEGATE TO COMPLETE

Patient's name: ____

Approved hospital OR assessment centre in which patient is being detained/assessed:

☐ NWRH (Burnie) ☐ LGH ☐ RHH ☐ Roy Fagan Centre ☐ Millbrook Rise Centre

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 CCP 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.

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

Name of Chief Civil Psychiatrist/delegate authorising the 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 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 – CCP/delegate to sign here:** ______________________________

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

We confirm that the CCP/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 ☐CCP (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 CIVIL PSYCHIATRIST / DELEGATE TO COMPLETE

Patient's name: ______________________________

Approved hospital OR assessment centre in which patient is being detained/assessed:

☐ NWRH (Burnie) ☐ LGH ☐ RHH ☐ Roy Fagan Centre ☐ Millbrook Rise Centre

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 CCP 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.

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

Name of Chief Civil 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 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 – CCP/delegate to sign here:** ______________________________

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

We confirm that the CCP/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 ☐ CCP (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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