



MHWA143

ROLLS AUSTRALIA 1300 600 192

JULY
2023

Mental Health and Wellbeing Act 2022 Sections 126, 127, 128, 131, 132, 133, 134, 135, 136, 137, 138 & 139 MHWA 143 Authority for use of chemical restraint										Local Patient Identifier															
										FAMILY NAME															
										GIVEN NAMES															
										DATE OF BIRTH					SEX		GENDER								
Mental Health Statewide UR Number										Place patient identification label above															
Instructions to complete this form																									
<ul style="list-style-type: none">This form must be completed to authorise the use of chemical restraint on a person receiving mental health and wellbeing services in a Designated Mental Health Service as soon as practicable after authorising the use of restraint.Part A of this form:Chemical restraint must be authorised by:<ul style="list-style-type: none">an Authorised Psychiatrist or Delegate; orif an Authorised Psychiatrist or Delegate is not reasonably available, a Registered Medical Practitioner or Nurse Practitioner.The use of chemical restraint for the purposes of transporting a person to or from a place as required by the Act can only be authorised by a Registered Medical Practitioner (complete point 23 in Part A).You can authorise the administration of up to 3 medications within a 15-minute period per form.An Authorised Psychiatrist or Delegate must be notified as soon as practicable if the chemical restraint is authorised by a Registered Medical Practitioner or Nurse Practitioner (complete point 24 in Part A).Part B of this form:The Authorised Psychiatrist or delegate must then examine the person as soon as practicable to decide whether continued use of the chemical restraint is necessary.If the Authorised Psychiatrist or Delegate is not available to examine the person, they must arrange for a Registered Medical Practitioner to examine the person as soon as practicable to decide whether continued use of the chemical restraint is necessary.																									
GIVEN NAMES										FAMILY NAME (BLOCK LETTERS) of patient															
<input type="checkbox"/> a Compulsory Patient <input type="checkbox"/> a Security Patient <input type="checkbox"/> a Forensic Patient																									
<input type="checkbox"/> a person receiving treatment in a Designated Mental Health Service on a voluntary basis																									
a patient of:																									
Designated Mental Health Service																									
Part A: Authorisation for use of chemical restraint																									
1. I am: <input type="checkbox"/> an Authorised Psychiatrist or Delegate <input type="checkbox"/> a Registered Medical Practitioner <input type="checkbox"/> a Nurse Practitioner																									
2. The reason for the use of the chemical restraint is: <input type="checkbox"/> to prevent imminent and serious harm to the person <input type="checkbox"/> to prevent imminent and serious harm to another person																									
3. All reasonable and less restrictive options have been tried or considered and found to be unsuitable.																									
4. I have given proper consideration to the decision-making principles for treatment and interventions.																									
5. Please explain why the chemical restraint was necessary:																									
6. Please detail all other less restrictive options tried or considered and explain why they were unsuitable:																									

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7. How many medications were administered? *No subsequent medication administrations can be added to this section after Part B of this form is completed and signed. <input type="checkbox"/> 1 <input type="checkbox"/> 2 medications within a 15-minute period <input type="checkbox"/> 3 medications within a 15-minute period																										
Administration 1																										
8. The following medication is required (select one option only):										<input type="checkbox"/> Antipsychotic <input type="checkbox"/> Benzodiazepine <input type="checkbox"/> Anaesthetic agent <input type="checkbox"/> Other (please specify)																
9. Route of administration:										<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Intramuscular <input type="checkbox"/> Intravenous <input type="checkbox"/> Other (please specify)																
10. Person responsible for prescribing medication:										Given Names:																
										Family Name:																
										Designation:																
11. Person responsible for administering medication:										Given Names:																
										Family Name:																
										Designation:																
12. Medication was administered on:										Date: Time: (24hr)																
Administration 2 (if required within 15 minutes of first administration)																										
13. The following medication is required (select one option only):										<input type="checkbox"/> Antipsychotic <input type="checkbox"/> Benzodiazepine <input type="checkbox"/> Anaesthetic agent <input type="checkbox"/> Other (please specify)																
14. Route of administration:										<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Intramuscular <input type="checkbox"/> Intravenous <input type="checkbox"/> Other (please specify)																
15. Person responsible for prescribing medication:										Given Names:																
										Family Name:																
										Designation:																
16. Person responsible for administering medication:										Given Names:																
										Family Name:																
										Designation:																
17. Medication was administered on:										Date: Time: (24hr)																
Administration 3 (if required within 15 minutes of first administration)																										
18. The following medication is required (select one option only):										<input type="checkbox"/> Antipsychotic <input type="checkbox"/> Benzodiazepine <input type="checkbox"/> Anaesthetic agent <input type="checkbox"/> Other (please specify)																
19. Route of administration:										<input type="checkbox"/> Oral <input type="checkbox"/> Sublingual <input type="checkbox"/> Intramuscular <input type="checkbox"/> Intravenous <input type="checkbox"/> Other (please specify)																
20. Person responsible for prescribing medication:										Given Names:																
										Family Name:																
										Designation:																
21. Person responsible for administering medication:										Given Names:																
										Family Name:																
										Designation:																
22. Medication was administered on:										Date: Time: (24hr)																

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										FAMILY NAME <div style="border: 1px solid black; height: 20px; width: 100%;"></div>									
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<div style="border: 1px solid black; height: 20px; width: 100%;"></div>										DATE OF BIRTH <div style="border: 1px solid black; height: 20px; width: 100%;"></div>					SEX <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		GENDER <div style="border: 1px solid black; height: 20px; width: 100%;"></div>		
Mental Health Statewide UR Number										Place patient identification label above									
Location *The use of chemical restraint for the purposes of transporting a person to or from a place as required by the Act can only be authorised by a Registered Medical Practitioner																			
23. Location where chemical restraint was administered (select one option only):										<input type="checkbox"/> Aged persons mental health residential service <input type="checkbox"/> Community based mental health service <input type="checkbox"/> Community Care Unit <input type="checkbox"/> Emergency Department <input type="checkbox"/> Mental health inpatient unit <input type="checkbox"/> Prevention and Recovery Centre (PARC) <input type="checkbox"/> Prior to or during transport to a Designated Mental Health Service* OR <input type="checkbox"/> Prior to or during transport to another place*									
Complete if Nurse Practitioner or Registered Medical Practitioner authorises chemical restraint if the Authorised Psychiatrist is not reasonably available.																			
24. I notified: _____ on: _____ at: _____ <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>										<div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div> <div style="border: 1px solid black; height: 20px; width: 100%;"></div>									
Signature: _____ <div style="border: 1px solid black; height: 20px; width: 100%;"></div>										Date: _____ <div style="border: 1px solid black; height: 20px; width: 100%;"></div>									
signature of Authorised Psychiatrist, Registered Medical Practitioner or Nurse Practitioner																			
Given Names: _____										Family Name: _____									
Part B: Authorisation for continued use of chemical restraint (if applicable) *To be completed by Authorised Psychiatrist, or if the Authorised Psychiatrist is not reasonably available, a Registered Medical Practitioner.																			
1. I am: <input type="checkbox"/> an Authorised Psychiatrist or Delegate <input type="checkbox"/> a Registered Medical Practitioner																			
2. I have examined the person and:																			
<input type="checkbox"/> I am not satisfied the continued use of chemical restraint is necessary and direct that no further chemical restraint is administered																			
<input type="checkbox"/> I am satisfied the continued use of chemical restraint is necessary, that all reasonable and less restrictive options have been tried or considered and found to be unsuitable and provide the following instructions regarding continued use below:																			
* Note: a new MHWA143 must be completed if it is necessary to administer any further chemical restraint																			
3. I have given proper consideration to the decision-making principles for treatment and interventions set out below.																			
Signature: _____ <div style="border: 1px solid black; height: 20px; width: 100%;"></div>										<div style="border: 1px solid black; height: 20px; width: 100%;"></div>									
signature of Authorised Psychiatrist or Delegate / Registered Medical Practitioner										date					time 24 hour				
Given Names: _____										Family Name: _____									

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Original – medical record

Notes

Victoria is working towards the elimination of restrictive interventions in mental health and wellbeing service delivery. Service providers should aim to reduce and eventually eliminate the use of restrictive interventions in mental health treatment.

1. Less restrictive options

Restrictive interventions must not be used unless all reasonable and less restrictive options have been tried or considered and have been found unsuitable. When considering if there are less restrictive options available you must, to the greatest extent possible in the circumstances, have regard to:

- The likely impact on the person;
- The person's views and preferences relating to restrictive interventions
- The person's culture, beliefs, values and personal characteristics.

2. Meeting the person's needs

A person who authorises the use of a restrictive intervention must ensure that the person's needs are met and the person's dignity is protected by the provision of appropriate facilities and supplies, including bedding and clothing appropriate to the circumstances, food and drink and adequate hygiene and toilet arrangements

3. Monitoring

A *MHWA 142 - Restrictive interventions observations* form must be completed and attached to this form to record the required clinical observations/reviews/examinations, noting the following requirements:

- a Registered Nurse or Registered Medical Practitioner must:
 - continuously observe a person subject to chemical restraint for not less than one hour after it is administered; and
 - clinically review a person as often as is appropriate, but not less frequently than every 15 minutes;
- an Authorised Psychiatrist must examine a person subject to a chemical restraint as often as the Authorised Psychiatrist is satisfied is appropriate in the circumstances to do so, but not less frequently than every 4 hours;
- if it is not practicable for an Authorised Psychiatrist to conduct an examination at the frequency that the Authorised Psychiatrist is satisfied is appropriate, the person must be examined by a Registered Medical Practitioner when so directed by the Authorised Psychiatrist.

4. Release from restrictive intervention

The person being restrained **must be released** from the restrictive intervention as soon as it is no longer necessary.

5. Use of a restrictive intervention on a person receiving treatment in a designated mental health service on a voluntary basis

An Authorised Psychiatrist or Delegate, a Registered Medical Practitioner or the Nurse Practitioner should review the person as soon as practicable to determine whether an Assessment Order should be made under section 144 of the *Mental Health and Wellbeing Act 2022*.

6. Notifications

As soon as practicable after the commencement of a restrictive intervention, the Authorised Psychiatrist must:

- **Notify** the following persons (as applicable) of the use of the intervention, the type of restrictive intervention and the reason for using it:
 - the primary non-legal mental health advocacy service provider;
 - the person's nominated support person;
 - the person's parent if the person is under the age of 16 years;
 - a carer, if the use of restrictive intervention will directly affect the care relationship between the carer and the person;
 - the person's guardian;
 - the DFFH Secretary, if that Secretary has parental responsibility for the person under a Relevant Child Protection Order.
- **Ensure** appropriate supports are provided to assist the person/s to understand this information.

7. Review

The Authorised Psychiatrist must ensure the use of chemical restraint is reviewed as soon as practicable after it ends and the person and support persons of their choosing must be offered an opportunity to participate in this review of the intervention with the Designated Mental Health Service. This review must be completed in a timely manner and carried out in accordance with any guidance from the Chief Psychiatrist.

Decision making principles for treatment and interventions

When authorising the use of restrictive interventions, you must give proper consideration to these principles.

Title	Principle
Care and transition to less restrictive support	Compulsory assessment and treatment is to be provided with the aim of promoting the person's recovery and transitioning them to less restrictive treatment, care and support. To this end, a person who is subject to compulsory assessment or treatment is to receive comprehensive, compassionate, safe and high-quality mental health and wellbeing services.
Consequences of compulsory assessment and treatment and restrictive interventions principle	The use of compulsory assessment and treatment or restrictive interventions significantly limits a person's human rights and may cause possible harm including— (a) serious distress experienced by the person; and (b) the disruption of the relationships, living arrangements, education or employment of the person.
No therapeutic benefit to restrictive interventions principle	The use of restrictive interventions on a person offers no inherent therapeutic benefit to the person.
Balancing of harm principle	Compulsory assessment and treatment or restrictive interventions are not to be used unless the serious harm or deterioration to be prevented is likely to be more significant than the harm to the person that may result from their use.
Autonomy principle	The will and preferences of a person are to be given effect to the greatest extent possible in all decisions about assessment, treatment, recovery and support, including when those decisions relate to compulsory assessment and treatment.

Definitions

- **'Bodily restraint'** means physical restraint, or mechanical restraint, of a person;
- **'Chemical restraint'** means the giving of a drug to a person for the primary purpose of controlling the person's behaviour by restricting their freedom of movement but does not include the giving of a drug to a person for the purpose of treatment or medical treatment;
- **'Compulsory patient'** means a person on an Assessment Order, Court Assessment Order, Temporary Treatment Order or Treatment Order;
- **'Nurse Practitioner'** means a registered nurse who is endorsed under the Health Practitioner Regulation National Law to practise as a nurse practitioner;
- **'Restrictive intervention'** means seclusion, bodily restraint, or chemical restraint.