MENTAL HEALTH ACT 2013: REVIEW OF THE ACT’S OPERATION

CONSULTATION DOCUMENT
Date: September 2019

This Consultation Document has been prepared by the Office of the Chief Psychiatrist to assist in reviewing the operation of the Mental Health Act 2013 (Tas).

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For further information, please contact:

Office of the Chief Psychiatrist
GPO Box 125
HOBART TAS 7001
Foreword

The Mental Health Act 2013 (Tas) was developed over many years with input and advice from a wide range of stakeholders.

When the Act commenced on 17 February 2014 it was rightly thought to represent a significant reform in how people who live with severe mental illness are assessed and treated.

The Tasmanian Parliament recognised this and included a requirement that the Minister for Mental Health and Wellbeing review the Act’s operation after six years of it commencing.

I have the pleasure, as Chair of the 2020 Review Project Steering Committee, of leading the review on behalf of the Minister for Mental Health and Wellbeing.

The Act has fundamentally changed how people who live with severe mental illness are assessed and treated in Tasmania. These changes have had an impact not only for clinicians and the Mental Health Tribunal but also for people who live with mental illness and their family members, friends and carers.

This review is an important way for Government to ensure the Act is working as originally intended.

The Act has been operational for five and a half years. There were some early teething problems and the Act was amended in 2017 to address these. There have also been some other minor and technical amendments along the way.

It’s important that we hear from people with lived experience of the Act, such as people who live with mental illness, and their family members, friends and carers about their experience of the legislation. We also want to hear from doctors, nurses and other health professionals who work with the Act every day.

This is your chance to share what you think.

The Act was developed to promote a consumer-centred approach and improve the protections available for people who live with mental illness in Tasmania. It was drafted to balance the ability for people with capacity to make their own treatment choices while enabling treatment to be given to people who lack decision-making capacity when needed. The Act also tries to balance consumer rights with the important role played by family, friends and carers of people who live with mental illness.

We are interested in hearing whether you think that the Act does these things and how well it does them.

We know that the review will highlight parts of the Act that could be improved. For example, doctors often say that they spend a lot of time completing forms and the Act should be amended to reduce this. It’s likely that this feedback will come through to us again, and that’s important.

There are many ways that you can contribute. One way is to read this document and answer some or all the questions that are posed in it. Another way is to write to us with your thoughts. We’re working closely with groups who represent the views of people who live with mental illness, carers, clinicians and others, and if you prefer you can provide feedback through these groups.

However you choose to contribute we look forward to hearing your views on the Act’s operation.

Dr Aaron Robert Groves
Chief Civil Psychiatrist and Chief Forensic Psychiatrist
Chair, Mental Health Act 2013 – 2020 Review – Project Steering Committee
2 September 2019
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How to Respond

Respondents are invited to provide feedback on the issues raised and questions asked in this Consultation Paper. Respondents can choose to answer any, or all, of the questions asked.

There are several ways to respond:

By completing a Response Template

- Respondents can complete a Response Template. Respondents can either complete the Template electronically or print the Template and complete it manually. Completed responses can be emailed or posted to the Office of the Chief Psychiatrist.

By making a detailed Submission

- Respondents can make a written submission. Written submissions can be emailed or posted to the Office of the Chief Psychiatrist. Respondents can choose to write on any, or all, aspects of the Act’s operation.

By providing feedback through a representative group or body

- Respondents can respond to the issues raised and questions asked through one of the representative groups or bodies listed in Appendix 1.

Responses received will be considered and used to inform a Report that will be provided to Tasmania’s Minister for Mental Health and Wellbeing and tabled in Tasmanian Parliament. Extracts from responses may also be published in other documents. Please let us know:

- If you do not want your response to be referred to or quoted from, or
- If you are happy for your response to be referred to or quoted from but for your identity as the author of the response to be kept confidential.

Responses can be emailed to chief.psychiatrist@health.tas.gov.au

Responses can also be posted to:

  Mental Health Act 2013 – 2020 Review  
  Office of the Chief Psychiatrist  
  Mental Health, Alcohol and Drug Directorate  
  GPO Box 125  
  HOBART TAS 7001

Inquiries should be directed to the Office of the Chief Psychiatrist on 03 6166 0778.

The closing date for responses is Friday, 8 November 2019.
Terms of Reference

The Minister for Mental Health and Wellbeing is required under section 229 of the Mental Health Act 2013 (the Act) to review the operation of the Act, and complete the review, within six years after the Act’s commencement.

The Minister is also required under section 229 to cause a Report on the outcome of the review to be tabled in each House of Parliament within 10 sitting-days of each House after the review is completed.

The Act commenced on 17 February 2014.

The review is necessary to satisfy the requirements of section 229 of the Act. The review also provides a mechanism for:

• satisfying stakeholder expectations that the Act’s operation will be reviewed
• facilitating feedback from stakeholders on aspects of the Act’s operation that impact on or concern them, and
• enabling issues with the Act’s operation to be identified and conveyed to the Minister for Mental Health and Wellbeing and the Minister for Justice, and for those issues to be reported to the Tasmanian Parliament.

Responses to the issues raised and questions in this document will inform a Report that identifies aspects of the Act’s operation that may require further consideration by Government.

Background to the Review

The Act was drafted in response to a review of the Mental Health Act 1996 (Tas).

The review process took place over several years and involved a wide range of stakeholders. When the Act came into effect on 17 February 2014 it was widely recognised as representing a significant reform in the legal framework for the care and treatment of people with serious mental illness.

When the Act was introduced Tasmania was the first jurisdiction in Australasia and one of only a handful of jurisdictions in the world to make consideration of a person’s decision-making capacity a threshold criterion for compulsory treatment for mental illness.

The Act also established a significantly different compulsory assessment and treatment pathway to the pathway established under the Mental Health Act 1996, shifted decision making responsibility from clinicians to independent statutory persons or bodies and introduced increased record keeping requirements and shifted with the aim of achieving greater transparency and improved safeguards and oversight.

Section 229 was inserted to the Act in recognition of these fundamental changes.

The Act is administered by the Minister for Mental Health and Wellbeing other than Parts 2 and 3 of Chapter 3, and Schedules 3, 4 and 5, which are administered by the Minister for Justice.
Governance Arrangements for the Review

Work occurred in late 2017/early 2018 to identify stakeholder views on the Act’s operation. This work consisted of:

- a roundtable discussion with key stakeholders within the Department of Justice including the President of the Mental Health Tribunal, the Deputy Secretary Administration of Justice, the Ombudsman, the Registrar of the Guardianship and Administration Board, the Public Guardian, the Anti-Discrimination Commissioner, the Tasmania Prison Service and staff of the Department of Justice’s Strategic Policy and Legislation Unit

- discussions with other stakeholders including the then Chief Civil Psychiatrist and Chief Forensic Psychiatrist, Tasmanian Health Service and Alcohol and Drug Services staff and staff of the Mental Health, Alcohol and Drug Directorate and Legal Services Units within the then Department of Health and Human Services, and

- discussions with other stakeholders including the Tasmania Law Reform Institute and the Tasmania Police Mental Health Liaison Officer.

Work to draft an Issues Paper commenced but was never completed.

In June 2019 the Secretary, Department of Health tasked Tasmania’s Chief Psychiatrist Dr Aaron Groves with responsibility for progressing the review of the Act’s operation and for completing the work that started in 2017.

Governance arrangements for the review feature:

- A Steering Committee comprised of:
  - Dr Aaron Groves, Chief Psychiatrist, Office of the Chief Psychiatrist, Mental Health, Alcohol and Drug Directorate.
  - Jeremy Harbottle, General Manager, Mental Health, Alcohol and Drug Directorate, Department of Health.
  - Kristy Bourne, Deputy Secretary Administration of Justice, Department of Justice.
  - Connie Digolis, Chief Executive Officer, Mental Health Council of Tasmania.

- A Statutory Reference Group comprised of Dr Groves, the Principal Official Visitor, the Public Guardian and the Commissioner for Children (or their nominees) and representatives from the Mental Health Tribunal, the Guardianship and Administration Board, the Tasmania Prison Service, Custodial Youth Justice, the Magistrates and Supreme Courts, the Legal Aid Commission of Tasmania, Tasmania Police and Ambulance Tasmania.

- A Clinical Reference Group comprised of Dr Groves and representatives from the Tasmanian Health Service, the Royal Australian and New Zealand College of Psychiatrists, the Australian College of Mental Health Nurses, general practice and primary health.

- A Consumer Reference Group comprised of Dr Groves, the Senior Consumer and Carer Liaison Consultant from the Office of the Chief Psychiatrist and representatives from Flourish Mental Health Action in Our Hands Inc., and Advocacy Tasmania.

- A Carer Reference Group comprised of Dr Groves, the Senior Consumer and Carer Liaison Consultant from the Office of the Chief Psychiatrist and representatives from Mental Health Carers Tasmania and Carers Tasmania.

Dr Groves is the Chair of the Steering Committee and of each of the Reference Groups.
Scope of the Review

Legislative amendment

Responses to the issues raised and questions in this document will inform a Report that identifies aspects of the Act’s operation that may require further consideration by Government.

It is outside the scope of this review to consider ways in which the Act may need to be amended to address the issues raised through the review.

Consideration of these issues, and the progression of any subsequent amendments to the Act, will occur as part of a separate process.

Intersecting legislation

The Act intersects with other Tasmanian legislation, including the Guardianship and Administration Act 1995 (Tas) and the Criminal Justice (Mental Impairment) Act 1999 (Tas).

It is outside the scope of this review to analyse the Guardianship and Administration Act, Criminal Justice (Mental Impairment) Act and other Tasmanian legislation that intersects with the Act.

Issues raised by respondents to this review that relate to the Guardianship and Administration Act, advance care directives, the defence of insanity and fitness to plead or other associated matters will be conveyed to the Department of Justice or other responsible Agency, to be considered as appropriate.
Executive Summary

The Minister for Mental Health and Wellbeing is required under section 229 of the Mental Health Act 2013 (the Act) to review the operation of the Act, and complete the review, within six years after the Act’s commencement.

This Consultation Paper has been prepared to provide respondents with the information needed to facilitate informed feedback on the Act’s operation.

The Paper provides a broad overview of the Act’s provisions in 18 Chapters as outlined below. It also asks a series of questions about the Act’s operation. These are summarised for convenience in a later Chapter.

Responses to the questions asked in this document, and other feedback received, will inform a Report that identifies aspects of the Act’s operation that may require further consideration by Government.

Chapter 1 Background and Context

This Chapter provides a brief overview of the planning, funding, service delivery and legislative context in which the Mental Health Act 2013 (Tas) operates.

Chapter 2 Overview of the Act’s provisions

Chapter 2 provides a broad overview of the Act’s provisions.

Chapter 3 The Act’s Objects and Mental Health Service Delivery Principles

Chapter 3 relates to the Act’s Objects and Principles.

Chapter 4 Key Concepts

Chapter 4 explains decision-making capacity and the meaning of mental illness as they apply to and under the Act.

Chapter 5 Assessment Framework

Chapter 5 provides an overview of the assessment framework established by the Act. It explores the meaning of assessment, assessment with informed consent and assessment under an Assessment Order.

Chapter 6 Treatment Framework

Chapter 6 provides an overview of the treatment framework established by the Act. It explores the meaning of treatment, treatment with informed consent, treatment that is authorised by the Mental Health Tribunal, urgent circumstances treatment and special psychiatric treatment.

Chapter 7 Assessment and Treatment for Children

Chapter 7 looks at how the Act operates for children. It explores assessment and treatment with informed consent, assessment and treatment as an involuntary patient and treatment in other circumstances.

Chapter 8 Protective Custody and Patient Escort

Chapter 8 looks at the Act’s protective custody and escort provisions.

Chapter 9 Involuntary Patients

Chapter 9 provides an overview of Assessment Orders and Treatment Orders, involuntary patient movements including involuntary patient leave, and involuntary patient rights.
Chapter 10 Forensic Patients

Chapter 10 provides an overview of matters related to the admission and detention of forensic patients, forensic patient movements including forensic patient leave, treatment for forensic patients, forensic patient management matters related to the operation of the secure mental health unit, and forensic patient rights.

Chapter 11 Seclusion and Restraint

Chapter 11 is concerned with seclusion and restraint for involuntary and forensic patients.

Chapter 12 Approved Facilities and Personnel

Chapter 12 is concerned with approved facilities (approved hospitals, approved assessment centres, secure mental health units and secure institutions) and approved personnel (Approved Medical Practitioners, approved nurses, Mental Health Officers and authorised persons).

Chapter 13 Information Management

Chapter 13 details provisions of the Act that relate to or are concerned with information management and record keeping requirements.

Chapter 14 Mental Health Tribunal

Chapter 14 provides information on the establishment, powers and functions of the Mental Health Tribunal including the Tribunal's review functions.

Chapter 15 Official Visitors

Chapter 15 provides information on the appointment, powers and functions of the Principal Official Visitor, and Official Visitors.

Chapter 16 Chief Civil Psychiatrist and Chief Forensic Psychiatrist

Chapter 16 provides information on the appointment, powers and functions of the Chief Psychiatrists.

Chapter 17 Interstate Arrangements

Chapter 17 is concerned with interstate transfer agreements, and interstate control agreements.

Chapter 18 Other Matters

Chapter 18 is concerned with matters that are not covered elsewhere including the rights and responsibilities of carers, offences and immunities.

Language Used in This Document

This document uses language that is generally consistent with the language used in the Act except with respect to the term “persons”, which has been replaced with “people” wherever possible.

A glossary of terms used frequently in this document is included at Appendix 2.
# Summary of Questions Asked

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| 9.5     | **Question 12:**  
Are provisions of the Act relating to Treatment Orders operating effectively? Are they clear and easy to understand? |
| 9.6.3   | **Question 13:**  
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| 9.7     | **Question 14:**  
Are involuntary patients being afforded the rights referred to in the Act and this document? If not, why do you think that is? |

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Are provisions for forensic patient movements and forensic patient leave operating effectively and efficiently? Are they clear and easy to understand? |
| 10.4.2.2| **Question 17:**  
Are provisions for the treatment of forensic patients operating effectively and efficiently? Are they clear and easy to understand? |
| 10.5.3  | **Question 18:**  
Are provisions for the management of forensic patients and the secure mental health unit operating effectively and efficiently? Are they clear and easy to understand? |
| 10.6.4  | **Question 19:**  
Are forensic patients being afforded the rights referred to in the Act and this document? If not, why do you think that is? |
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| 18.3 | **Question 29:**  
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1. Background and Context

It has been estimated that almost half (45 per cent) of the Australian population aged 16 – 85 will experience a mental illness at some point in their life and that two to three per cent of all Australians have a severe mental illness, as judged by diagnosis, intensity and duration of symptoms, and degree of disability caused. Another four to six per cent of the population are estimated to have a moderate disorder and a further nine to 12 per cent are estimated to have a mild disorder1.

The Act provides a framework to enable treatment to be given to the very small number of people with severe mental illness who do not have capacity to decide about assessment or treatment for themselves. It also provides for the management of forensic patients.

There have been several reforms in mental health internationally, nationally and across Australian jurisdictions since the Act’s development.

1.1 National Context

1.1.1 Mental Health Planning

Mental health services in Australia have been shaped by the National Mental Health Policy and its revision in 2008, together with a series of national mental health plans. Implementation of these plans has seen a shift from institutionalised care to supported care in the community and more recently a stronger focus on person centred and recovery orientated approaches, and mental health promotion, prevention and early intervention. Upholding the rights and strengthening the participation of consumers, carers and their families at all levels has become central to the way mental health services are now planned, delivered and evaluated across Australia.

The Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan) includes actions that focus on improving the consistency of mental health legislation across jurisdictions and commits all governments to working together to achieve integrated regional planning and service delivery. Consumers, carers and safety and quality measures are also an integral part of the Fifth Plan and inform how services are planned, delivered and evaluated. Other areas of focus include suicide prevention, physical health of people living with a mental illness and reducing early mortality, improving Aboriginal and Torres Strait Islander mental health and suicide prevention and reducing stigma and discrimination for people with a mental health illness2.

The Roadmap for National Mental Health Reform 2012-2022 (Roadmap) provides an overarching focus and vision for all national and jurisdictional mental health policies, strategies and ongoing reform. The Roadmap sets out the ongoing reform that is necessary to achieve the vision of a society that values and promotes the importance of good mental health and wellbeing, maximises opportunities to prevent and reduce the impact of mental health issues and mental illness and supports people with mental health issues and mental illness, their families and carers to live full and rewarding lives.

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The Roadmap sets out six priorities which will act as building blocks for ongoing reform, as follows:

- **Priority 1**: Promote person-centred approaches
- **Priority 2**: Improve the mental health and social and emotional wellbeing of all Australians
- **Priority 3**: Prevent mental illness
- **Priority 4**: Focus on early detection and intervention
- **Priority 5**: Improve access to high quality services and supports
- **Priority 6**: Improve the social and economic participation of people with mental illness

Safety and quality in mental health care has been a key priority nationally and has been influenced and supported by the development of the National Standards for Mental Health Services 2010 (National Standards), the National Mental Health Statement of Rights and Responsibilities 2012, and movement towards the elimination of seclusion and restraint in Australian mental health services through the development of National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services.

The National Framework for Recovery-Oriented Mental Health Services was developed in 2013 and is based around the needs of consumers, carers and their families utilising their lived experience of mental health to inform treatment and support. Self-determination, personal responsibility and self-management are a key focus of the framework. The framework aligns with the current national focus on rights, recovery orientated approaches and supported recovery identified in the National Standards and broader reform agendas.

### 1.1.2 Funding and Service Delivery

Mental health services in Tasmania are funded by both the Tasmanian and Australian Governments. The Australian Government provides Medicare and grant-based funding and policy direction for the delivery of primary mental health care services by General Practitioners (GPs), private psychologists, nurses and other allied health professionals, as well as providing core funding to Aboriginal Community Controlled Health Services.

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3 The Roadmap can be accessed here:


5 The Statement can be found here: [www1.health.gov.au/internet/main/publishing.nsf/content/E39137B3C170F93ECA257CBC007CFC8C/$File/rights2.pdf](http://www1.health.gov.au/internet/main/publishing.nsf/content/E39137B3C170F93ECA257CBC007CFC8C/$File/rights2.pdf) (last accessed 29 August 2019)


The Australian Government also provides funding for a range of specialist mental health services including:

- psychological support through the National Disability Insurance Scheme
- funding for the aged care sector including funding for mental health programs for older Australians in residential aged care facilities
- funding to subsidise medicines through the Pharmaceutical Benefits Scheme
- funding for Headspace centres
- funding for the National Suicide Prevention Trial in Northern Tasmania
- national projects such as the National Education Initiative
- projects that are provided by multiple organisations such as Beyond Blue.

In Tasmania, the community-managed sector generally operates on a not-for-profit basis and is funded by both the Tasmanian and Australian Governments. It includes both large and small organisations, some with statewide coverage and many different programs, and some that operate in only one region. These services often have strong connections with local communities and can engage those communities to deliver better social outcomes for consumers and carers.

The private health sector provides professional fee-based services in both inpatient and office-based settings. These services include primary mental health care, acute specialist management, rehabilitation, psychological interventions and other allied health-based supports. Private sector professionals and organisations are substantial contributors to overall service delivery in mental health with their funding provided by a mix of individual payments and Australian Government rebates.

The Australian Government, through its programs, primarily focuses on funding services for those Tasmanians with mild to moderate levels of mental illness in need of treatment, most of whom will access services through their GP.

### 1.1.3 Legislative Developments

Every jurisdiction in Australia has its own mental health legislation. Since the Act’s introduction, several other jurisdictions have reviewed their mental health legislation and have introduced new Acts, as follows:

- The **Mental Health Act 2015** (ACT) came into effect on March 2016. The Act is designed to empower people to participate in decisions about their health care and sets out the legal responsibilities of doctors and other professionals. It promotes consumer involvement in decision-making and contains provisions that support consumers to make their own decisions.

- The **Mental Health Act 2016** (Qld) commenced in March 2017. The Act’s objects include to improve and maintain the health and wellbeing of people who have a mental illness and who do not have the capacity to consent to be treated.

- The **Mental Health Act 2014** (Vic) seeks to place people with mental illness at the centre of decision-making about their treatment and care. It encourages psychiatrists and other mental health practitioners to develop strong relationships with people using mental health services, and to provide them with information and support to make informed choices about their care. It promotes voluntary treatment over compulsory treatment.

- The **Mental Health Act 2014** (WA) commenced in November 2015. It is primarily relevant to people experiencing mental illness who, because of the seriousness of the illness and issues in compliance with treatment, need to be made subject to involuntary status.
1.2 Tasmanian Context

1.2.1 History of the Mental Health Act 2013 (Tas)

The Mental Health Act 2013 (the Act) was developed in response to a review of the Mental Health Act 1996, which together with the Guardianship and Administration Act 1995 (Tas) had previously regulated the treatment and care of people with mental illness.

The review process found that working between the two Acts was unnecessarily complex and that the framework did not provide an appropriate level of review or safeguards for people being involuntarily treated for a mental illness.

The Act was developed following extensive public and targeted consultation and with assistance from a wide range of stakeholders to ensure that people with mental illness are treated within a framework that is consistent with a human rights approach, that is focussed on consumers and their rights.

The Act is intended to be rights-focussed, and to reflect notions of consumer autonomy. It establishes what is effectively a substitute decision-making framework for people with mental illness who, because of their illness, lack decision-making capacity and cannot make their own assessment and treatment decisions in circumstances where treatment is needed to prevent harm to the person’s health or safety or the safety of others.

The Act introduced decision-making capacity as a threshold test for determining whether people with a mental illness can be involuntarily treated. On this basis, the legislation does not enable a person with mental illness to be involuntarily treated or detained if they have decision-making capacity.

The Act sought to remedy the difficulties associated with the previous legislative framework, which saw decisions about a person’s treatment being made under the Guardianship and Administration Act, with decisions about treatment setting made under the Mental Health Act 1996, by establishing a streamlined and clarified treatment pathway featuring a single Treatment Order enabling treatment across a range of settings.

Prior to the Act’s commencement, decisions about treatment settings for people with serious mental illness were made by medical practitioners while decisions about treatment were commonly made by family members, carers or friends of the person. The Act sought to address difficulties associated with this decision-making model by enabling treatment decisions to be made by an independent Tribunal comprised of legal and medical experts (the Mental Health Tribunal).

Another main aim of the Act was to provide clarity for clinicians, people with experience of mental illness and their families and carers by clearly setting out the rights that consumers have under the Act.

The Act was amended in 2016 to clarify and improve the Act’s operation in response to feedback received from clinicians and the Mental Health Tribunal (MHT) about certain aspects of the legislation. The 2016 amendments took effect on 1 July 2017.

Other more recent amendments to the Act include:

- removal of the requirement for the MHT to review a person’s admission to an approved facility before a division of three members chosen by the President of the Tribunal, and
- technical amendments to the interstate transfer provisions to facilitate interstate transfers of forensic patients.

Amendments to remove the requirement for the MHT to review admissions before a division of three members took effect in May 2019 while amendments to the interstate transfer provisions took effect in June 2019.
1.2.2 Mental Health Planning

The Tasmanian Government released *Rethink Mental Health: A long-term plan for Mental Health in Tasmania 2015-2025* (Rethink) in 2015 following an extensive stakeholder consultation process. Rethink sets a vision for Tasmania to be a community where all people have the best possible mental health and wellbeing and brings together actions to strengthen mental health promotion, prevention and early intervention, to improve care and support for people with mental illness, their families and carers. It includes short, medium and long-term actions to develop an integrated mental health system that provides support in the right place, at the right time and with clear signposts about where and how to get help.

Approaches to achieving integration of mental health services in Southern Tasmania were considered by the Mental Health Integration Taskforce (the Taskforce). The Taskforce noted slow progress in achieving the commitment set out in Rethink to develop an integrated mental health system and considered reasons for this over a 12-month period from March 2018 to March 2019. The Taskforce made 21 recommendations for achieving lasting system change. Amongst other key reforms the Taskforce recommended establishing a 24-hour integrated service hub that consists of a range of collocated social services, disability support services, peer-operated services and clinical services, built around ensuring the recovery concept and supported by sub-acute residential services.

In 2016 the Tasmanian Government released an updated *Tasmanian Carer Policy*. The policy recognises the commitment of unpaid Tasmanian carers and supports them in their caring role, and their active participation in economic, social and community life for themselves and the people they care for. The findings of Mental Health Carers Tasmania’s *Caring Voices Project* also provided insight into the role of, and issues faced by, mental health carers in Tasmania.

1.2.3 Funding and Service Delivery

The Tasmanian Government funds public sector services and sets legislative, regulatory and policy frameworks for mental health service delivery.

Public sector mental health services are provided across Tasmania through the Tasmanian Health Service. Services include:

- 24-hour acute inpatient services located at three public hospitals (the Royal Hobart Hospital, the Launceston General Hospital and the North West Regional Hospital Burnie Campus)
- a 24-hour older persons acute/sub-acute inpatient unit located in the South providing services to people across the state (the Roy Fagan Centre)
- a 24-hour step up/step down facility located in the South (Mistral Place)
- 24-hour specialist extended treatment units located in the South and providing services to people across the state (the Millbrook Rise Centre and Tolosa Street)
- child and adolescent, older persons and adult community mental health services that operate throughout the state

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• adult community mental health teams that provide crisis, assessment and treatment and triage services
• a 24-hour statewide helpline and triage service – the Mental Health Services Helpline, and
• community and inpatient care for people with a mental illness who are involved with, or who are a risk of involvement with, the justice system (community forensic mental health services teams and the Wilfred Lopes Centre).

A Mental Health Hospital in the Home (MHHITH) service also commenced operation in March 2019. MHHITH provides intensive hospital-level treatment and operates with extended hours, seven days a week.

The Tasmanian Government also funds a range of community-based organisations to provide services including:
• psychosocial support services
• individual packages of care
• residential rehabilitation
• community-based recovery and rehabilitation
• peer support groups
• prevention and brief intervention services, and
• advocacy and peak body representation for consumers, carers and service providers.

The Tasmanian public mental health service is primarily designed to provide a range of clinical services to people living with the most severe forms of mental illness.

1.2.4 Legislative Developments

1.2.4.1 Guardianship and Administration Act 1995 (Tas)

The Tasmania Law Reform Institute (TLRI) recently reviewed the Guardianship and Administration Act. The review, which concluded in December 2018, recommends a major overhaul of the state’s guardianship laws. The Institute’s recommendations include removal of the need to establish that a person has a disability and refocussing on whether a person can make decisions with the use of appropriate support.

Amongst other matters the Institute also considered the issue of advance care directives and recommended that:

• Tasmania adopt a legislative framework for advance care directives and that the legislative framework for advance care directives be included in the Guardianship and Administration Act (Recommendation 5.1), and
• an advance care directive or instrument not be permitted to contain directions that relate to mandatory treatment, for example under the Mental Health Act 2013 (Tas). Any direction of this type should be void and of no effect (Recommendation 5.6).

The Government’s views on the Institute’s recommendations will be considered in due course.

1.2.4.2 Defence of Insanity and Fitness to Plead

The Tasmania Law Reform Institute is also in the process of reviewing the Defence of Insanity in section 16 of the Criminal Code Act 1924 and fitness to plead and released an Issues Paper on these topics in February 2019.
1.3 Other Developments

1.3.1 United Nations Convention on the Rights of Persons with Disabilities

The United Nations Convention on the Rights of Persons with Disabilities (the CRPD) was ratified by the Australian government on 17 July 2008. Under Article 12 of the CRPD, people with disabilities have the same right to make their own decisions as everyone else and should be given the proper support they need to make these decisions. Other forms of decision making (such as substitute decision making) should be a last resort.

All Australian jurisdictions are required to adopt strategies to pursue these obligations for all people with disabilities, including those with mental health impairments.

1.3.1.1 Supported Decision-Making

In 2014 the Australian Law Reform Commission (ALRC) reviewed the effect of the Convention on Australian law. The ALRC identified four national decision-making principles that uphold the articles of the convention and provide consistency for legislation within Australian jurisdictions that include a decision-making component, as follows:

- Principle 1: All adults have an equal right to make decisions that affect their lives and to have those decisions respected.
- Principle 2: People who require support in decision-making must be provided with access to the support necessary for them to make, communicate and participate in decisions that affect their lives.
- Principle 3: The will, preferences and rights of people who may require decision-making support must direct decisions that affect their lives.
- Principle 4: Laws and legal frameworks must contain appropriate and effective safeguards in relation to interventions for people who may require decision-making support, including to prevent abuse and undue influence.

1.3.2 Optional Protocol to the Convention Against Torture

The Australian Government ratified the Optional Protocol to the United Nations Convention Against Torture (OPCAT) in December 2017. OPCAT establishes a two-part system for inspecting places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment. The places of detention to be inspected include closed facilities or units where people may be involuntarily detained by law for mental health assessment or treatment and closed forensic disability facilities or units where people may be involuntarily detained by law for care, where people are held for equal to, or greater than, 24 hours. In Tasmania, this encompasses approved hospitals and approved assessment centres, and secure mental health units.

The first part of the system is periodic visits to places of detention conducted by the United Nations Subcommittee for the Prevention of Torture (the UN Subcommittee). Australia is obliged to receive visits from the UN Subcommittee now that OPCAT is in effect. The second part of the system is the establishment of Australia’s domestic monitoring obligations under OPCAT by establishing and maintaining a cooperative network of monitoring bodies known as National Preventative Mechanisms or NPMs designated by the Australian Government and state and territory governments. The Australian Government elected to defer the establishment of NPM networks for three years.

The Act provides for the assessment and treatment of people with mental illness, and related matters, as follows:

- Chapter 1 of the Act defines key terms, confirms how particular concepts underpinning the Act’s provisions are to be interpreted and identifies the Act’s objects, status and principles.

- Chapter 2 of the Act provides for the assessment, treatment and management of patients
  - Part 1 of Chapter 2 of the Act refers to the mental health service delivery principles and identifies the circumstances in which a patient may be given treatment.
  - Part 2 of Chapter 2 of the Act applies to and regulates protective custody.
  - Part 3 of Chapter 2 of the Act applies to involuntary patients. It provides for and regulates Assessment Orders, Treatment Orders, treatment plans, urgent circumstances treatment, seclusion and restraint, patient movements and the circumstances in which an involuntary patient can be admitted to a secure mental health unit. It also sets out the rights of involuntary patients under the Act.
  - Part 4 of Chapter 2 of the Act applies to the admission and custody of forensic patients and regulates forensic patient leave.
  - Part 5 of Chapter 2 of the Act applies to the treatment and management of forensic patients. Amongst other matters it provides for and regulates force, seclusion and restraint, visits, telephone calls and mail, searches, and judicial and related matters. It also sets out the rights of forensic patients under the Act.
  - Part 6 of Chapter 2 of the Act applies to special psychiatric treatment.
  - Part 7 of Chapter 2 of the Act applies to information management and related matters.
  - Part 8 of Chapter 2 of the Act applies to approved personnel and facilities.

- Chapter 3 of the Act provides for oversight and review
  - Part 1 of Chapter 3 provides for the appointment and features of office of the Chief Psychiatrists and for Clinical Guidelines and Standing Orders.
  - Part 2 of Chapter 3 provides for the appointment, powers and functions of Official Visitors, and for visits, complaints and reporting mechanisms.
  - Part 3 of Chapter 3 provides for the establishment, functions and powers of the Mental Health Tribunal. It also provides for the Tribunal’s review functions.

- Chapter 4 provides for interstate transfer agreements and interstate control agreements.
- Chapter 5 provides for miscellaneous matters including offences and legal and administrative matters.
- Schedule 1 outlines the mental health service delivery principles.
- Schedule 2 outlines the custody and escort provisions.
- Schedules 3 and 4 relate to the Mental Health Tribunal.
- Schedule 5 relates to Official Visitors.
3. The Act’s Objects and Mental Health Service Delivery Principles

An Act’s objects and principles are important because they jointly determine how the Act’s provisions should be interpreted and applied.

3.1 Objects

The Act’s objects are set out in section 12. They are:

• to provide for the assessment and treatment of people with mental illnesses
• to provide for appropriate oversight and safeguards in relation to such assessment and treatment
• to give everyone involved with such assessment and treatment clear direction as to their rights and responsibilities
• to provide for such assessment and treatment to be given in the least restrictive setting consistent with clinical need, legal and judicial constraints, public safety and patient health, safety and welfare
• to promote voluntary over involuntary assessment and treatment and the making of free and informed assessment and treatment choices, and
• to provide for all incidental and ancillary matters.

The objects recognise the vulnerability of people with mental illness who do not have decision-making capacity and the need for assessment and treatment decisions to be transparent, and subject to independent oversight and scrutiny.

Question 1:
Are the Act’s provisions being interpreted and applied in a way that promotes the Act’s objects?

3.2 Mental Health Service Delivery Principles

Section 15 of the Act requires people exercising responsibilities under it to have regard to the mental health service delivery principles set out in Schedule 1 to the Act.

The mental health service delivery principles are set out in full at Appendix 3.

Question 2:
Are people exercising responsibilities under the Act doing so in a way that has regard to the mental health service delivery principles?
4. Key Concepts

4.1 Decision-Making Capacity

A person’s right to decide whether to have or undergo treatment for an illness is a fundamental expression of individual autonomy, and respecting this right is a vital component of person-centred care.

Increased involvement of health consumers in decision making processes is consistent with key national and international frameworks including the CRPD which emphasises respect for the individual autonomy and independence of people with disability (including people with mental illness), including the freedom for a person to make their own choices.

The ability for a competent adult to make autonomous decisions about medical treatment is also a legal right that is protected under Common Law. This includes the right for a competent adult to refuse medical treatment even if the decision is not sensible, rational or well considered, or if the refusal is reasonably likely to lead to death or serious injury.

These principles are reflected in the Act’s objects, which include promoting voluntary over involuntary assessment and treatment and the making of free and informed assessment and treatment choices. They are also reflected in the Act’s principles, which require everyone exercising responsibilities under the legislation to respect, observe and promote the inherent rights, liberty, dignity, autonomy and self-respect of people with mental illness and to interfere with or restrict the rights of people with mental illness in the least restrictive way and to the least extent consistent with the protection of those people and the public, and the proper delivery of the relevant service.

Within this context, the Act specifically recognises the ability for a person with decision-making capacity to make his or her own decisions about assessment and treatment for a mental illness. It reinforces the need for an adult’s decision-making capacity to be presumed and outlines how a person’s decision-making capacity can be assessed when this is in doubt.

The Act also provides guidance with respect to a child’s decision-making capacity. The Act reflects a presumption against children having decision-making capacity which is consistent with the legal position that applies generally in relation to consent to treatment where the person is a child. It also recognises that some children may have decision-making capacity and identifies when this may be the case.

The test for decision-making capacity for adults, and the test for decision-making capacity for children, are set out in subsections 7(1) and 7(2) of the Act respectively.

Each of the tests confirms that an adult or child may be taken to understand information on the consequences of making the decision (including making the decision one way or the other, deferring the decision, and not making the decision at all) if it reasonably appears to the person (or body) considering it that the adult or child is able to understand an explanation of the nature and consequences of the decision when the explanation is given in a way that is appropriate to his or her circumstances. The tests also confirm that an adult or child may be taken to be able to retain information on the consequences of making the decision (including making the decision one way or the other, deferring the decision, and not making the decision at all) even if the adult or child can only retain the information for a short period of time.

4.1.1 Other Developments

The TLRI’s recent review of the Guardianship and Administration Act considered the test for decision-making capacity set out in the Act and recommended (at Recommendation 6.3) that the Guardianship and Administration Act adopt the term ‘decision-making ability’ when referring to a person’s ability to make decisions or give consent. The review also recommended that the definition of ‘decision-making ability’ used in the Guardianship and Administration Act be consistent with the definition of ‘decision-making capacity’ contained in the Mental Health Act 2013.

The TLRI also considered the role of supported decision-making and recommended that:

- the definition of decision-making ability contained in the Guardianship and Administration Act confirm that a person has decision-making ability if they can make a decision with practicable and appropriate support, and
- a person may only be determined to lack decision-making ability if all practicable steps have been taken to provide the person with appropriate support to make and communicate a decision.

Question 3:
Is the test for decision-making capacity set out in section 7 of the Act operating effectively? Is it easy to understand and apply for both adults and children?

4.2 Meaning of Mental Illness

The meaning of mental illness set out in section 4 of the Act establishes a legal threshold which must be met before the legislation may be taken to apply.

The meaning of mental illness is intended to include conditions for which the provisions of the Act may be necessary and/or appropriate, while excluding conditions for which the coercive mechanisms available under the Act – including compulsory assessment, treatment and potentially detention in an approved facility – are inappropriate.

The meaning is included in the Act to ensure that the Act is not applied arbitrarily. This is particularly important because of the significant nature of the powers available under the Act to police officers, MHOs, medical practitioners and the MHT if a person is found to have a mental illness as defined by the Act.

The Act does not define mental illness in terms of diagnosis. Rather the Act defines mental illness based on behaviours or symptoms typically displayed or exhibited by a person with mental illness for which provisions of the Act may be appropriate.

The meaning of mental illness is extracted in full at Appendix 4.

The Chief Civil Psychiatrist Clinical Guideline 1 – Meaning of Mental Illness clarifies how the meaning of mental illness is to be applied in practice. The Clinical Guideline was first released in 2014 and remains largely unamended. It is available online here:

Question 4:
Is the meaning of mental illness set out in section 4 of the Act operating as intended? Is it easy to understand and apply?
5. Assessment Framework

5.1 Meaning of Assessment

For the purposes of the Act, assessment is defined in section 5 as the clinical process involved in diagnosing the condition of a person’s mental health and, where necessary, identifying the most appropriate treatment. The Act refers to assessment with informed consent and identifies the circumstances in which a person’s consent to assessment may be taken to be informed. It also refers to assessment under authority of an Assessment Order.

5.2 Assessment with Informed Consent

The circumstances in which a medical practitioner may take a person’s consent to assessment as being informed for the purposes of the Act are set out in section 8 of the Act. Specifically, section 8 requires a medical practitioner to be satisfied that the person has decision-making capacity at the time he or she gives the consent, has given consent freely and has had a reasonable opportunity to make the decision.

5.3 Assessment under an Assessment Order

A person may be assessed without informed consent under authority of an Assessment Order. The criteria that must be met before an Assessment Order can be made, and the actions that can be taken with respect to a person’s assessment once the person is placed on an Assessment Order are detailed further in Chapter 9 of this document.

Question 5:
Is the assessment framework established by the Act operating effectively? Is it easy to understand and apply?

5.4 Assessment Without Informed Consent or an Assessment Order

The Supreme Court has considered whether assessment can occur without informed consent or under an Assessment Order in an unreported judgment.

The judgment concerned the situation of a person who was assessed in her home without her informed consent or an Assessment Order. The person was unaware that an assessment was taking place or that a possible outcome was that a Treatment Order might be applied for. She instead believed she was having a friendly chat and a cup of tea. According to the person, she would not have let the treating team into her home had she known the possible outcome of the visit. The evidence of the assessment undertaken during the friendly chat was used by the treating team to apply for, and obtain, a Treatment Order. The person, who was represented by the Legal Aid Commission of Tasmania, argued that the assessment was unlawfully obtained and that it was a mistake of law to have relied on the evidence. The Court held that the person’s informed consent was not required because under section 37(2) of the Act, an application may be made regardless of whether the person is subject to an Assessment Order.

The question of whether a person should be assessed only either with informed consent or under an Assessment Order was not contemplated when the Act was drafted.

Question 6:
Should the Act specifically regulate, or prevent, assessment without informed consent or an Assessment Order?
6. Treatment Framework

6.1 Meaning of Treatment

For the purposes of the Act, treatment is defined in section 6 as the professional intervention necessary to:

- prevent or remedy mental illness, or
- manage and alleviate, where possible, the ill effects of mental illness, or
- reduce the risks that people with mental illness may, because of the illness, pose to themselves or others, or
- monitor or evaluate a person’s mental state.

This includes the range of interventions that may be necessary to treat a person’s mental illness, including medication, Electro-Convulsive Therapy and other interventions that may be needed to reduce the risk that a person with a mental illness may, because of the illness, pose to themselves or to others.

General health care is excluded from the scope of the definition. This is because the Act is concerned with providing for the assessment and treatment of people with mental illness rather than with the provision of general health care. Authority for the provision of general health care to and for people with a disability who are incapable of giving consent to that care is regulated under the Guardianship and Administration Act and the Act does not impact on this. Termination of pregnancy, procedures that could make a person permanently infertile and removal of tissue that cannot be replaced naturally for transplantation purposes are also excluded from the definition for this reason.

Seclusion, chemical restraint, mechanical restraint and physical restraint are also specifically excluded from the meaning of treatment. This is because the Act recognises these practices as restrictive interventions rather than treatments and regulates them as such.

Lastly the definition excludes special psychiatric treatment. Special psychiatric treatment is regulated specifically in Part 6 of Chapter 2 of the Act as a special category of professional intervention. Special psychiatric treatment is excluded from the definition of treatment to ensure that it is not inadvertently authorised as a form of treatment and outside of the framework established in Part 6 of Chapter 2. More information about special psychiatric treatment and the circumstances in which it may be authorised is provided further on in this Chapter.

The meaning of treatment has relevance for the authorisation of urgent circumstances treatment and the authorisation of treatment by the MHT as it describes the type and nature of the professional interventions that may be authorised.

When considered alongside the meaning of the assessment, the meaning of treatment is intended to ensure authority to provide continuum of care for people with mental illness who lack decision making capacity in relation to assessment and treatment.

There may be some involuntary patients, including people who are in the recovery phase of a serious mental illness, for whom evaluation and monitoring of their condition is a critical component of their treatment. Conversely there may be some patients in the early stages of a mental illness who require evaluation and monitoring to determine the efficacy of medications or other treatments provided. The meanings of assessment and treatment, when read together, are intended to capture these scenarios.
6.2 When May Treatment Be Given?

The circumstances in which treatment may be given under the Act are summarised in section 16 of the Act as follows:

- A voluntary patient may:
  - be given treatment with informed consent, and
  - be given special psychiatric treatment, but only if the special psychiatric treatment is authorised by the MHT under the Act and, if the special psychiatric treatment is psychosurgery or a treatment that the regulations require be given only with informed consent, if informed consent has been given for the treatment.

- An involuntary patient may:
  - be given treatment:
    - with informed consent, or
    - if the treatment is authorised by a Treatment Order, or
    - if the treatment is authorised as urgent circumstances treatment, and
  - be given special psychiatric treatment but only if the special psychiatric treatment is authorised by the MHT under the Act and, if the special psychiatric treatment is psychosurgery or a treatment that the regulations require be given only with informed consent, if informed consent has been given for the treatment.

- A forensic patient, or an involuntary patient who has been admitted to a secure mental health unit under section 63 of the Act, may:
  - be given treatment:
    - with informed consent, or
    - if the treatment is authorised by the MHT, or
    - if the patient is also an involuntary patient, if the treatment is authorised by a Treatment Order, or
    - if the treatment is authorised as urgent circumstances treatment, and
  - be given special psychiatric treatment but only if the special psychiatric treatment is authorised by the MHT under the Act and, if the special psychiatric treatment is psychosurgery or a treatment that the regulations require be given only with informed consent, if informed consent has been given for the treatment.

6.2.1 Treatment with Informed Consent

The circumstances in which a medical practitioner may take a person’s consent to treatment as being informed for the purposes of the Act are set out in section 8 of the Act. Specifically, section 8 requires a medical practitioner to be satisfied that the person has decision-making capacity at the time he or she gives the consent, has given consent freely and has had a reasonable opportunity to decide. Section 8 also sets out the criteria that must be met before a person may be taken to have had a reasonable opportunity.
Additional obligations apply to the off-label use of medications. These are set out in Chief Civil Psychiatrist Clinical Guideline 7 Off-Label Use of Medications, which can be accessed online here: www.dhhs.tas.gov.au/__data/ assets/pdf_file/0005/374693/CCP_Clinical_Guideline_7_-_Off-Label_Use_of_Medications.pdf

6.2.2 Treatment That is Authorised by the Mental Health Tribunal

The MHT may authorise treatment for an involuntary patient by way of a Treatment Order. The circumstances and how this may occur are detailed further in Chapter 9 of this document.

The MHT may authorise treatment for a forensic patient in the circumstances set out in sections 88 and 91 of the Act. More detail is provided in Chapter 10 of this document.

The same additional obligations that apply to the off-label use of medications with informed consent apply to the authorisation of treatment by the MHT. These are set out in Chief Civil Psychiatrist Clinical Guideline 7 Off-Label Use of Medications, which can be accessed online here: www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/374693/CCP_Clinical_Guideline_7_-_Off-Label_Use_of_Medications.pdf

6.2.3 Urgent Circumstances Treatment

As noted earlier in this Chapter, the treatment framework established by the Act enables a person to be given treatment with informed consent, if the treatment is authorised by the MHT, or if the treatment is urgent circumstances treatment. This is consistent with the Act’s objects which include the promotion of voluntary over involuntary assessment and treatment and the making of free and informed assessment and treatment choices, and the provision of appropriate oversight and safeguards in relation to the assessment and treatment of persons with mental illness.

As noted further on in this document, the Act provides for Assessment Orders. Assessment Orders provide authority for a person to be assessed, without informed consent, by an approved medical practitioner (AMP) to confirm whether the person meets the assessment criteria and to determine if the person also meets the treatment criteria. Assessment Orders do not, however, provide authority for a person to be given any treatment.

As also noted further on in this document, the Act provides for Treatment Orders. Treatment Orders provide authority for a person to be given, without informed consent, the treatment, or type of treatment specified in the Order.

There may be occasions when a person on an Assessment Order requires urgent treatment, for example to prevent the person from becoming significantly unwell. There may also be occasions when a person on a Treatment Order requires treatment that is different from the treatment or type of treatment specified in the Order.

The urgent circumstances treatment provisions enable a person to be given treatment that is urgently needed in the patient’s best interests, without informed consent or the need for MHT authorisation, in circumstances where achieving the necessary treatment outcome would be compromised by waiting for the urgent circumstances treatment to be authorised by the MHT (or by a member of the MHT on an interim basis).

This ensures continuity of care and the ability to intervene within a framework which requires decisions about involuntary treatment to be made independently, and to be oversighted.

The circumstances in which urgent circumstances treatment may be authorised for an involuntary patient are set out in section 55 of the Act. The circumstances in which urgent circumstances treatment may be authorised for a forensic patient are, in turn, set out in section 87 of the Act.
In each case, urgent circumstances treatment may only be authorised if the AMP authorising it is of the opinion that achieving the necessary treatment outcome would be compromised by waiting for the urgent circumstances treatment to be authorised by the MHT, or by a member of the MHT on an interim basis.

Sections 55 and 87 each require the AMP to have formed this opinion following an examination of the person. Sections 55 and 87 also impose certain obligations on the AMP including confirming any authorisation that is given verbally in writing and ensuring that the person is told about the authorisation as soon as possible.

Urgent circumstances treatment may be given only until:

- the treatment is finished
- an AMP stops the treatment
- 96 hours after the authorisation
- if the person is an involuntary patient, until the Assessment Order, Treatment Order or interim Treatment Order that the person is subject to expires or is discharged
- if the person is a forensic patient, until the person is discharged from a secure mental health unit, or
- the MHT sets the authorisation aside.

Chief Civil Psychiatrist Standing Order 8 directs medical practitioners and others in the authorisation of urgent circumstances treatment for involuntary patients while Chief Forensic Psychiatrist Standing Order 8 directs medical practitioners and others in the authorisation of urgent circumstances treatment for forensic patients. The Orders are intended to ensure that urgent circumstances treatment is authorised and given appropriately, safely and in a way that respects the dignity and rights of patients.

Chief Civil Psychiatrist Clinical Guideline 8 and Chief Forensic Psychiatrist Clinical Guideline 8 provide more general guidance on the use of urgent circumstances treatment for involuntary patients and forensic patients respectively, with a focus on reducing the use of urgent circumstances treatment wherever possible.


### 6.2.4 Emergency Treatment

In relation to emergencies, it is generally recognised that a doctor may do whatever is necessary to avert an imminent risk of death or serious injury without the need to seek consent at Common Law. Treatment in these circumstances is given routinely in emergency settings for people with general health and mental health conditions.

The Act does not regulate emergency treatment.

Emergency treatment may be given to a person who has a mental illness and is under the Act in the same way that it may be given to a person with mental illness who is not under the Act. The treatment in this circumstance is however regulated by the Common Law, not the Act.
Where additional or ongoing treatment is needed, and the emergency criteria no longer apply, then either informed consent or authorisation from the MHT or from an AMP via the urgent circumstances treatment provisions will continue to be required.

**Question 7:**

Is the treatment framework established by the Act operating effectively? Is it easy to understand and apply?
6.3 Special Psychiatric Treatment

The Act regulates special psychiatric treatment in Part 6 of Chapter 2 (sections 122 – 128).

6.3.1 What is Special Psychiatric Treatment?

The term “special psychiatric treatment” is defined in section 122 to mean psychosurgery, or any treatment that the regulations declare to be special psychiatric treatment. Psychosurgery is in turn defined to mean either:

- the use of surgery or intracerebral electrodes to create a lesion in a person’s brain to permanently alter the person’s thoughts, emotions or behaviour, or
- the use of intracerebral electrodes to stimulate a person’s brain (without creating a lesion) to temporarily alter or influence the person’s thoughts, emotions or behaviour.

At the time of writing, no treatments were declared by the regulations to be special psychiatric treatments.

6.3.2 When May Special Psychiatric Treatment Be Given?

Under section 124 of the Act, a person (including a person who is an involuntary patient or a forensic patient) may only be given special psychiatric treatment if:

- the treatment has been authorised by the MHT in writing and before the treatment is given, and
- the treatment is psychosurgery, or another type of special psychiatric treatment that the regulations require is given only with informed consent, if informed consent has been given for the treatment.

The Act takes special psychiatric treatment very seriously and makes it an offence for a person to give a person psychosurgery without the MHT’s authorisation and the patient’s informed consent. In the case of registered health practitioners, the Act confirms that this is also professional misconduct.

The Act limits the circumstances in which the MHT may authorise special psychiatric treatment, as follows:

- Under section 125 of the Act, the MHT may only authorise special psychiatric treatment if an AMP (who has assessed the person in the past seven days), a Chief Psychiatrist, an independent expert and the MHT agree on relevant matters including that the special psychiatric treatment is, having regard to the patient’s condition and treatment history, and the risk and benefits of the special psychiatric treatment, a reasonable and appropriate treatment for the patient.
- Under section 126 of the Act, the MHT is required to hold a hearing before at least three members and to agree unanimously on the special psychiatric treatment before authorising it.

6.3.3 Use of Special Psychiatric Treatment in Tasmania

Special psychiatric treatment has not been authorised for a person in Tasmania since the Act’s commencement in 2014. As such, the provisions of the Act that relate to special psychiatric treatment have not been used.

Question 8:

Are the special psychiatric treatment provisions of the Act operating effectively? Are they easy to understand and apply?
7. Assessment and Treatment for Children

7.1 Assessment and Treatment with Informed Consent

The Act confirms the ability for a parent to give informed consent for the assessment or treatment of a child who lacks decision-making capacity and says when this may occur for the purposes of the Act in section 9.

The Act confirms that consent from one parent is enough to provide authority for assessment or treatment, but that consent from each parent is required for consent to be withdrawn.

Enabling one parent to consent is not intended to discourage, hinder or prevent efforts to locate each parent of the child and to have discussions with each parent about assessment or treatment that is proposed for the child. It is also not intended to prevent more than one parent from consenting to the child’s assessment or treatment.

Proceeding in this way is a part of good clinical practice and the Act is not intended to override this. Rather the intention is to provide certainty for clinicians about whether they may lawfully treat a child, while recognising that not all family situations are the same. For example, there may be occasions when it is not possible or appropriate to seek out and obtain informed consent from each parent of the child. This may include where it is not possible to locate a parent, or where a parent is concerned about the impact that providing the consent may have on their relationship with the child and elects not to do so. The intention of section 9 of the Act is to enable treatment to be given to children when this may be the case.

In terms of withdrawal of consent the requirement for each parent of the child to withdraw the consent is similarly intended to ensure certainty in relation to the withdrawal. This is relevant given the ability for a child to be assessed or treated based on consent given by only one of the child’s parents. Within this context, the withdrawal of consent by only one parent would not remove authority for the child to be assessed or treated with consent.

The requirement for consent to be withdrawn by each person with parental responsibility for the child is intended to provide certainty to parents, children and clinicians, about whether there is authority to assess or treat the child with consent.

Ensuring clarity in this area is particularly relevant given the consequences of a decision to withdraw or refuse to give consent for a child to be assessed or treated with consent.

Specifically, refusal or withdrawal of consent for assessment or treatment which is thought to be necessary may result in an application being made for authority from the Family or Supreme Court, or the MHT, for the child’s assessment or treatment with respect to a mental illness.

These are significant steps which should only be taken only when this is necessary and when it is not possible or feasible to have the child assessed or treated with consent.

For the purposes of relevant provisions, the term “parent” is defined to mean a person who has, for a child, all the responsibility which, by law, a parent has in relation to his or her children. The intention is to accommodate the range of people who may be appropriate to provide consent to treatment on a child’s behalf. This includes biological parents and persons named in a parenting order made under the Family Law Act 1975 (Cth). It also captures a person who has or who has been granted guardianship of a child under the Children, Young Persons and their Families Act 1997 (Tas).

For children who are under the guardianship of the Secretary of the Department of Communities Tasmania under the Children, Young Persons and their Families Act, decisions about medical treatment may be made by a delegate. Who this will be in practice depends on the type of treatment.
A child who is provided with assessment or treatment with informed consent from a parent has the status of a voluntary patient under the Act. This means that the restrictions and oversight mechanisms that may otherwise be available had the child been an involuntary patient (such as the requirements of the Act associated with regulation of seclusion and restraint, and the ability for a person with standing to apply to the MHT for a review of relevant decisions) do not apply. Instead, the usual rules and protocols applying to the treatment of children in place within the relevant treatment service apply.

7.2 Assessment or Treatment as an Involuntary Patient

The Act does not prevent an Assessment Order or Treatment Order being made for a child.

Circumstances in which an Order may be made include if the child’s parents are unavailable, unable or unwilling to provide informed consent to the assessment or treatment. An Assessment Order or Treatment Order may also be made if there is a dispute between the child’s parents as to whether consent should be given.

The Act recognises the special vulnerability of children who are involuntary patients as follows:

- The Act limits the circumstances in which a child may be admitted to and detained in approved hospital to those in which the person or body authorising the admission is satisfied that the relevant hospital has facilities and staff to assess or treat the child and is the most appropriate place to accommodate him or her in the circumstances. Provisions in which this limitation applies include section 27 (relating to Assessment Orders), sections 38, 39, 47 and 47A (relating to Treatment Orders) and section 181 (relating to the MHT’s review of Treatment Orders).

- In respect of the admission of an involuntary patient who is a child to a secure mental health unit, section 63 of the Act requires the Chief Forensic Psychiatrist (CFP) to be satisfied that the child can be detained separately from adult patients and that the probable benefits of accommodating the person in the secure mental health unit outweigh the probable risks.

- The Act also requires any authorisation of seclusion or chemical restraint, mechanical restraint or physical restraint for a child to be authorised by the relevant Chief Psychiatrist or a delegate. This essentially limits the decision to authorise seclusion or restraint for a child to an experienced psychiatrist.

- The need to take special care with decisions to seclude or restraint children is emphasised in Chief Civil Psychiatrist and Chief Forensic Psychiatrist Standing Orders 9, 10 and 10A, and in Chief Civil Psychiatrist and Chief Forensic Psychiatrist Clinical Guidelines 9, 10 and 10A relating to seclusion and restraint.

- In respect of the MHT, the Act confirms that a parent of a child is a party to any proceedings concerning the child.

7.3 Treatment in Other Circumstances

The Act recognises in section 219 the possibility that consent to treatment may, in exceptional circumstances, be given for a child by the Supreme Court or Family Court and confirms that treatment given under authority of the Court is not unlawful.

This is in recognition of existing methods for resolving differences of opinion between parents about whether they should give consent on behalf of a child who lacks decision-making capacity for psychiatric treatment which may, in some cases, require the difference to be resolved through the Family Court or Supreme Court.
Section 219 is intended to resolve any ambiguity about the ongoing role of these Courts in respect of treating that is proposed or given under the Act.

Section 219 is not intended to replace or supplant existing mechanisms which exist to resolve disputes between parents of children about treatment and care matters concerning those children.

Section 219 also does not impact on the MHT’s ability to authorise assessment or treatment for a child who lacks decision making capacity, where the assessment or treatment criteria are met, where there is no Court order refusing treatment, and where this is otherwise appropriate in the circumstances.

**Question 9:**

Is the Act operating effectively to facilitate treatment for children? If not, why do you think this is?
8. Protective Custody and Patient Escort

Protective custody is a coercive mechanism designed to get a person who is a risk to self or others because of a mental illness to a place of safety so that the person’s mental health can be evaluated by a professional. It can be invoked without a warrant and without the need to confirm whether the person is subject to an Assessment or Treatment Order or whether there is any other legal process in train with respect to the person. The Act regulates protective custody in sections 17 – 21.

The Act also refers throughout to circumstances in which a person may be taken under escort. The circumstances in which this may occur are set out in full at Appendix 5.


8.1 Protective Custody

Under section 17 of the Act, a police officer or MHO may take a person into protective custody if the officer reasonably believes that:

- the person has a mental illness
- the person should be examined to see if he or she needs to be assessed against the assessment criteria or the treatment criteria, and
- the person’s safety or the safety of others is likely to be at risk if the person is not taken into protective custody.

Schedule 2 confirms that patients should not be taken into protective custody if they can be properly examined and assessed against the assessment criteria or treatment criteria without being taken into protective custody. This is consistent with the Act’s objects which are to provide for assessment and treatment to be given in the least restrictive setting, and with the mental health service delivery principles which require any person exercising responsibilities under the Act to interfere with or restrict the rights of people with mental illness in the least restrictive way, and to the least extent consistent with the protection of those people and the public, as well as the proper delivery of the relevant service.

Under section 18 of the Act, an MHO or police officer who has taken a person into protective custody must escort the person to an approved assessment centre and this must occur as soon as is practicable.

8.1.1 Examination by a Medical Practitioner

Under section 19 of the Act, a person who has been taken into protective custody and escorted to an approved assessment centre must be seen by a medical practitioner within four hours of the person’s arrival. The purpose of the examination is to see whether the person needs to be assessed against the assessment criteria or treatment criteria.

Schedule 2 confirms that there is no requirement for the MHO or police officer to be in close physical proximity to the person during any examination or assessment.

8.1.2 Handover

Under Schedule 2 of the Act, an MHO or police officer who has taken a person into protective custody may transfer physical control of the person to another MHO or police officer. That person then has, and may exercise, any of the powers that the original MHO or police officer had in respect of the custody.

An MHO or police officer who takes a person into protective custody to an approved assessment centre may ask any MHO at the approved assessment centre to take over the person’s custody. Under section 18
of the Act an MHO at the approved assessment centre who is asked to take over custody in this manner to comply with the request, unless it would be unsafe in the circumstances to do so.

Section 18 of the Act also confirms that a person’s protective custody is not taken to have been interrupted or terminated merely because physical control of the person has been handed over from one MHO or police officer to another such officer.

8.1.3 Release

An MHO or police officer who has a person in protective custody must release the person from that custody if, at any time:

- informed consent is given to assess or treat the person
- an Assessment Order or Treatment Order is made for the person, or
- the MHO or police officer reasonably forms the belief that the person no longer meets the criteria for being taken into protective custody.

A person who has been taken to an approved assessment centre in protective custody must be released from custody after four hours of the person’s arrival, if none of these things have happened.

This is to prevent a person from remaining in protective custody at an approved assessment centre for more than four hours.

8.2 Patient Escort

The circumstances in which a person may be taken under escort for the purposes of the Act are set out in full at Appendix 5.

8.2.1 Handover

Under Schedule 2 of the Act, an MHO, police officer or authorised person who has taken a person under escort may transfer physical control of the person to another MHO, police officer or authorised person. That person then has, and may exercise, any of the powers that the original MHO, police officer or authorised person had in respect of the escort.

8.3 Matters in Common

The custody and escort provisions set out in Schedule 2 apply to and expand on matters relating to protective custody and patient escort.

8.3.1 Custody and Escort Policy

Schedule 2 provides that, as far as practicable:

- people should not be taken into or held in protective custody or taken or held under escort by force unless persuasion or other non-forceful methods have been tried without success or the MHO, police officer or authorised person reasonably believes that it would be futile or inappropriate to try such methods
- whenever practicable, the use of custodians and escorts other than police officers is to be preferred, and
- people taken into protective custody or under escort should be transported with the least delay and discomfort as circumstances reasonably allow.
8.3.2 General Powers

A police officer, MHO or authorised person who is authorised or empowered by the Act to take a person into protective custody or under escort or to hold a person in custody or under escort, may do the following to undertake that function:

- enlist the assistance of any person, including, if necessary, a police officer
- use reasonable force against the person if he or she resists being taken into protective custody or under escort
- use reasonable force against anyone who may try to prevent the person from being taken into protective custody or under escort
- without warrant and doing as little damage as possible, enter any premises if it is reasonably believed that the person may be found on those premises
- take possession of and safeguard any medication, physical aid or other thing that it is reasonably believed is or may be necessary to the person’s health, safety or welfare, or
- take possession of and safeguard any medication, prescription or other thing that it is reasonably believed is or may be relevant to the person’s examination, assessment, treatment or care.

8.3.3 Search Powers

A police officer, MHO or authorised person who is authorised or empowered by the Act to take a person into protective custody or under escort or to hold a person in custody or under escort, may do the following to undertake that function:

- conduct a frisk search or ordinary search of the person and seize anything found in the search in relevant circumstances, and
- retain anything seized and either safeguard the thing to return later, or dispose of as the police officer, MHO or authorised person thinks fit.

Schedule 2 imposes requirements on a police officer, MHO or authorised person who intends to conduct a search and requires any frisk search that is conducted to be conducted, if practicable, by a person of the same sex as the person being searched.

8.3.4 Identification Requirements

Schedule 2 clarifies requirements associated with identification. Schedule 2 specifically requires a police officer, MHO or authorised person who is asked by a person (or prospective patient), a representative or support person of a person (or prospective patient), the owner or occupier of any premises or the controlling authority of any facility that the officer or authorised person is trying to enter or a Chief Psychiatrist to produce proof of identity to do so.

Question 10:
Are the protective custody and escort components of the Act operating effectively? Are they clear and easy to understand?
9. Involuntary Patients

The Act defines an involuntary patient as a person who is subject to an Assessment Order or a Treatment Order.

The Act regulates Assessment Orders in sections 22 – 35 of the Act and Treatment Orders in sections 36 – 49 of the Act.

9.1 Assessment Orders

An Assessment Order is a short-term order made by a medical practitioner that authorises a person’s assessment, without the person’s informed consent, by an AMP to confirm whether the person meets the assessment criteria and to determine if the person also meets the treatment criteria.

Once made, an Assessment Order is authority for any MHO or police officer to take the person under escort to ensure that he or she presents for assessment. In some cases, an Assessment Order may also be authority for the person’s admission to and detention in an approved facility for and in connection with that assessment.

Assessment Orders may provide for matters that are incidental to the person’s assessment that the medical practitioner making the Order thinks are necessary or desirable to provide for in the circumstances.

9.1.1 Application

While section 23 of the Act identifies the people that may apply for an Assessment Order, no application is required for an Order to be made. This is confirmed in section 24 of the Act.

9.1.2 When May an Assessment Order be Made?

The circumstances in which a medical practitioner can make an Assessment Order are set out in section 24. They include that the person in respect of whom the Order is made has been examined by the medical practitioner in the 24-hour period immediately before the Order is made and that the medical practitioner is satisfied from the examination that the person needs to be assessed against the assessment criteria.

The Act requires Assessment Orders to be documented using a Chief Civil Psychiatrist Approved Form and to include the information set out in section 26 of the Act. Orders that do not meet these requirements are invalid.

9.1.2.1 Assessment Criteria

The assessment criteria are set out in section 25. They are that:

• the person has, or appears to have, a mental illness that requires or is likely to require treatment for the person’s health or safety or the safety of others

• the person cannot be properly assessed regarding the mental illness or the making of a Treatment Order except under the authority of the Assessment Order, and

• the person does not have decision-making capacity.
9.1.3 Independent Assessment

Once an Assessment Order is made the following applies:

- the Order takes effect as soon as it is signed by the medical practitioner who makes it
- the person must be assessed by an AMP other than the medical practitioner who applied for or made the Order. Under section 30 of the Act, this independent assessment must occur within 24 hours of the order taking effect
- the AMP must immediately either affirm or discharge the Order. The AMP can affirm the Order if he or she is satisfied that the person meets the assessment criteria. The AMP can discharge the Order for “sufficient” cause. This includes if the AMP does not think that the person meets the assessment criteria
- if the Order is affirmed – the AMP may extend the Order’s operation by up to 72 hours, calculated from when the AMP affirms the Order. The affirmation must be documented and takes effect as soon as the instrument is signed
- if the Order is discharged – the AMP must follow the process set out in section 35 of the Act.

9.1.4 Duration

An Assessment Order that has not been affirmed, or that has been affirmed but not extended in operation, ceases to have effect after 24 hours of being made.

An Assessment Order that has been affirmed and extended in operation ceases to have effect at the end of the period of extension.

An Assessment Order that is discharged ceases to have effect when it is discharged.

An Assessment Order automatically ceases to have effect when a Treatment Order is made for the person.

The maximum time for which an Assessment Order can stay in place is 96 hours.

9.1.5 Discharge

An Assessment Order may be discharged at any time for “sufficient cause” by the medical practitioner who made it, by any AMP (including the AMP who conducts an independent assessment), or by the MHT.

The Act does not define “sufficient cause”. It does however (in section 35) state that a medical practitioner has “sufficient cause” to discharge an Assessment Order if he or she is satisfied, after examining the person or on other reasonable grounds, that the person does not meet the assessment criteria.

The Act also does not define “other reasonable grounds”. The intention is to refer to grounds which are reasonable in the circumstances. This might include information about the person’s state of mental health that has been provided by another medical practitioner, or by a member of nursing staff.

**Question 11:**

Are provisions of the Act relating to Assessment Orders operating effectively? Are they clear and easy to understand?
9.2  Treatment Orders

A Treatment Order is an Order made by the MHT that provides authority for a person to be given the treatment (or type of treatment) that is specified in the Order, without the person’s informed consent.

Under section 42 of the Act, a Treatment Order also provides authority for a person to be admitted to, and if necessary detained in, an approved facility, or type of approved facility:

• for the purposes of receiving treatment, if the terms of the Order permit this, or
• if sections 47 or 47A apply in relation to the person, until:
  o the Order is varied to provide for a different treatment setting, or
  o the Order ceases to have effect under the Act.

The circumstances in which sections 47 or 47A apply are set out further on in this Chapter.

A Treatment Order is additionally authority for an MHO or police officer to take a person under escort to ensure that he or she presents for treatment under the Order.

9.2.1  Applications

Any AMP may apply to the MHT for a Treatment Order.

For people who are subject to an Assessment Order when the application is made, the applicant may only make the application if he or she has assessed the person under authority of the Assessment Order and is satisfied from the assessment that the person meets the treatment criteria.

For people who are not subject to an Assessment Order when the application is made, the applicant may only make the application if the person has been assessed by the applicant, and by one other AMP, within the previous seven days. The assessments must be conducted separately, and the applicant and the AMP must both be satisfied from their assessments that the person meets the treatment criteria.

Procedural and documentation requirements associated with applications are set out in section 37 of the Act.

Applications last for up to 10 days only. Applications that have not been considered by the MHT in that time lapse and are considered invalid.

9.2.2  Determination of Applications

The MHT can make a Treatment Order for a person in the circumstances set out in section 39 of the Act.

The Tribunal must be satisfied of the following matters:

• that the application requirements set out in section 37 have been met
• that the person meets the treatment criteria, and
• that a treatment plan has been prepared for the person and that this has occurred in consultation with the person and with other people, if relevant.

The MHT is required to determine an application as soon as practicable after the application is received, and must do so at a hearing before at least three MHT members.
9.2.2.1 Treatment Criteria

The treatment criteria for a person are set out in section 40. They are that:

• the person has a mental illness, and
• without treatment, the mental illness will, or is likely to, seriously harm the person’s health or safety or the safety of other people, and
• the treatment will be appropriate and effective in terms of the outcomes referred to in section 6 of the Act, and
• the treatment cannot be adequately given except under a Treatment Order, and
• the person does not have decision-making capacity.

9.2.2.2 Treatment Plans

Treatment plans are provided for in sections 50 – 54 of the Act.

According to these sections, a treatment plan is an instrument that sets out an outline of the treatment a person is to receive. The Act requires each involuntary patient to have a treatment plan.

Under section 53 of the Act, a treatment plan can be prepared by any medical practitioner involved in an involuntary patient’s treatment or care. The medical practitioner must consult the patient when preparing the plan. The practitioner may also consult other people, but only after consulting the patient about this.

An involuntary patient’s treatment plan can be varied at any time as set out in section 54 of the Act.

9.2.2.3 Interim Treatment Orders

A single member of the MHT can make an interim Treatment Order for a person in the circumstances set out in section 38 of the Act. Amongst other matters the MHT member must be satisfied that:

• the application requirements set out in section 37 have been met
• the person meets the treatment criteria
• the MHT cannot immediately determine the application, and
• the delay that would be involved in waiting for the MHT to determine the application if the interim Treatment Order was not made would, or is likely to, seriously harm the person’s health or safety or the safety of other people.

The MHT member can make the interim Treatment Order after considering the application alone, and without conducting a hearing or making any further inquiries.

9.2.3 Form and Content of Treatment Orders

The Act requires Treatment Orders to be in a set form and to contain the information listed in section 41 of the Act.

Under sections 38 and 39 of the Act, a Treatment Order or interim Treatment Order may include a requirement that the treatment setting for a person be a specified approved hospital or approved assessment centre or type of approved facility other than a secure mental health unit, or a premises or place or type of premises or place.

A Treatment Order or interim Treatment Order may also enable a person to be admitted to and if necessary detained in an approved hospital or approved assessment centre or type of approved facility other than a secure mental health unit, for the purposes of receiving treatment.
Treatment Orders and interim Treatment Orders may additionally provide for a combination of treatment settings, and for the admission and re-admission of the person to those settings.

As with Assessment Orders, Treatment Orders may specify or provide for matters that are incidental to the person’s treatment and that the MHT considers necessary or desirable to provide for in the circumstances.

### 9.2.4 Failure to Comply With Treatment Orders

Section 47 specifies the actions that a person’s treating medical practitioner can take if the person fails to comply with a Treatment Order. This includes:

- applying to the MHT to vary the Treatment Order
- having the person admitted to and, if necessary, detained in an approved hospital or approved assessment centre, and
- authorising or seeking authorisation of urgent circumstances treatment.

The actions set out in section 47 of the Act may only be taken if:

- reasonable steps have been taken to obtain the person’s compliance with the Treatment Order to which he or she is subject, and
- the person’s treating medical practitioner is satisfied on reasonable grounds that:
  - the person has failed to comply with the Treatment Order, despite the reasonable steps that have been taken to obtain compliance
  - the failure by comply has seriously harmed, or is likely to seriously harm, the person’s health or safety or the safety of others, and
  - the harm or likely harm cannot be addressed adequately except through a treatment or treatment setting that is inconsistent with the Treatment Order.

### 9.2.5 Admission to Prevent Possible Harm

The steps that a person’s treating medical practitioner can take if the person has complied with the Treatment Order but nevertheless presents a risk to self or others are set out in section 47A of the Act.

In this circumstance, the person’s treating medical practitioner may seek to have the person taken under escort and involuntarily admitted to, and detained in, an approved facility.

This action may be taken only if:

- the person is subject to a Treatment Order that provides for a combination of treatment settings and for the admission and re-admission of the person to those settings
- the person has complied with the Order
- the treating medical practitioner is satisfied on reasonable grounds that:
  - despite the person’s compliance with the Order, his or her health or safety or the safety of another person has been, or is likely to be, seriously harmed, and
  - the harm or likely harm cannot be addressed adequately other than through the person’s admission or re-admission to, and if necessary, detention in an approved hospital.
9.2.6 Procedural Requirements

The actions that must be taken by an applicant for a Treatment Order and procedural requirements associated with applications are set out in section 37 of the Act.

The actions that the MHT or a member of the MHT (in the case of an interim Treatment Order) is required to take on making a Treatment Order are set out in section 45 of the Act.

9.3 Renewal of Treatment Orders

Under section 47 of the Act, the MHT may renew a Treatment Order on application by an AMP.

An application must be made at least 10 days before the Treatment Order is due to expire, and an application made less than 10 days before this date is invalid.

The MHT is to determine an application as soon as practicable after it has been made and must do so at or following a hearing.

Procedural requirements associated with applications and actions that must be taken by the MHT on renewing a Treatment Order, are set out in section 48 of the Act.

9.4 Duration of Treatment Orders

A Treatment Order (including an interim Treatment Order) takes effect as soon as it is made.

An interim Treatment Order lasts until the original application is determined by the MHT or after 10 days, if the MHT has not determined an original application by then.

A Treatment Order that has been determined by the MHT at a hearing continues in effect for up to six months.

A Treatment Order that has been renewed lasts for up to six months if the Order has not been renewed before, or up to 12 months if the Order has already been renewed.

9.5 Discharge of Treatment Orders

A Treatment Order may be discharged by an AMP, or by the MHT.

The circumstances in which a Treatment Order may be discharged by an AMP are set out in section 49 of the Act. Under section 49, an AMP must discharge a Treatment Order if he or she is satisfied, after assessing the person while the Order is in effect, that the person does not meet the treatment criteria. In some cases, consultation with the person’s treating medical practitioner may be required.

Procedural requirements associated with discharges are set out in section 49 of the Act.

The MHT also has authority to discharge a Treatment Order. The circumstances in which this may occur are set out in section 181 of the Act.

Question 12:
Are provisions of the Act relating to Treatment Orders operating effectively? Are they clear and easy to understand?
9.6 Involuntary Patient Movements

9.6.1 Involuntary Patient Transfer Between Approved Hospitals

When and how an involuntary patient may be transferred from one approved hospital to another is set out in section 59 of the Act.

Under section 59 of the Act, the Chief Civil Psychiatrist (CCP) (or a delegate) may direct an involuntary patient’s transfer from one approved hospital to another if he or she is satisfied that the transfer is necessary for the person’s health or safety or the safety of other people.

A transfer direction issued by the CCP or a delegate in accordance with section 59 is authority for an MHO to take the person under escort, for the MHO to remove the person from the transferring hospital and for the MHO to take the person to the other hospital.

Once the person has been transferred, the Treatment Order that the person is subject to has effect as if it provided for the person’s involuntary admission to, and if necessary, detention in, the new approved hospital.

9.6.2 Involuntary Patient Leave

When and how an involuntary patient may be granted leave is set out in section 60 of the Act.

Leave may be granted to an involuntary patient for personal reasons, or for clinical reasons.

Under the Act, personal reasons (for granting a person leave of absence) include visiting a sick or dying relative or close friend, attending a relative or close friend’s funeral, wedding or graduation or attending a special religious event or service. Clinical reasons (for granting a person leave of absence) include facilitating the person’s rehabilitation or reintegration to the community, furthering the person’s treatment, and reasons deemed appropriate by the person authorised to grant the leave.

Leave for personal reasons may be granted on the application of the patient, or another person who has, in the opinion of the AMP considering the application, a genuine interest in the patient’s welfare. Patients who apply for leave themselves are required to be given help to do so. Leave for clinical reasons does not require an application.

Leave may be granted for a continuous period of up to 14 days and may be subject to conditions, including that the person must be under escort during the leave or any part of the leave.

Leave that has been granted may be extended (provided the total period of leave is less than a continuous period of 14 days), varied or cancelled.

An AMP who refuses an application for leave is required under section 60 of the Act to give notice of the refusal to the person who applied for the leave, and to the patient if the patient was not the applicant.

9.6.3 Absence Without Leave

An involuntary patient who is absent from an approved hospital without leave, or who has taken leave of absence but failed to comply with the leave, whose leave is cancelled or whose leave has expired without the person returning to the approved hospital, may be taken into protective custody by an MHO or police officer and returned to the approved hospital under section 61 of the Act.

Question 13:

Are provisions of the Act relating to involuntary patient transfers and leaves of absence operating effectively? Are they clear and easy to understand?
Involuntary Patient Rights

The Act seeks to achieve a consumer-centred, rights-based framework for assessment and treatment of people with mental illness.

In particular, the Act does not enable a person with decision making capacity to be assessed, treated or detained against their will. The Act also makes decision-making capacity a criterion for determining whether the legislation applies.

The Act's objects include to:

• provide for the assessment and treatment of people with mental illness to be given in the least restrictive setting consistent with clinical need, legal and judicial constraints, public safety and patient health, safety and welfare, and

• to promote voluntary over involuntary assessment and treatment and the making of free and informed assessment and treatment choices.

The Act also requires people exercising responsibilities under the legislation to have regard to principles, including;

• to respect, observe and promote the inherent rights, liberty, dignity, autonomy and self-respect of people with mental illness

• to interfere with or restrict the rights of people with mental illness in the least restrictive way and to the least extent consistent with the protection of those persons, the protection of the public and the proper delivery of the service, and

• to promote the ability of people with mental illness to make their own choices.

The Act also provides involuntary patients with certain specific rights. They include:

• The right to be given a written statement that sets out and explains the rights that a patient or prospective patient has in key circumstances (a Statement of Rights), and other important documentation, at various points throughout the patient’s assessment and treatment pathway in relevant circumstances.

• The right to ask the CCP to intervene directly regarding the person’s assessment, treatment or care. This right is set out in section 147 of the Act.

• The right, as a person with standing, apply to the MHT to review certain matters. These rights are set out in Part 3 Division 2 of the Act.

• The right to receive help from the controlling authority of an approved facility in making an application to the MHT, including through having reasonable access to an Australian lawyer, advocate, translator or other person on whose skills a person may need to rely on to make the application. This right is set out in section 195 of the Act.

• The right to apply to the MHT, as a person with standing, for an Order, determination, direction, or other document to be corrected. This right is set out in section 224A of the Act.

• The right to have information given to him or her in a language or form that the person understands, using an interpreter or alternative augmentative communication system if necessary. This right is set out in section 135 of the Act.

• The right to attend hearings held in proceedings to which the person is a party, and to appear personally or be represented by an Australian legal practitioner, advocate or other person. This right is set out in Schedule 4 Part 2 of the Act.
• The right when attending proceedings before the MHT to be dressed in ordinary (rather than institutional) clothing, as far as this is practicable. This right is set out in Schedule 4 Part 2 of the Act.

• The rights set out in section 62 of the Act.

The circumstances in which an involuntary patient is required to be given a Statement of Rights, and the rights that involuntary patients have under section 62 of the Act, are set out in full at Appendix 6.

**Question 14:**

Are involuntary patients being afforded the rights referred to in the Act and this document? If not, why do you think this is?
10. Forensic Patients

A forensic patient is defined to mean a person who has been admitted to a secure mental health unit under section 68 of the Act, and who has not been discharged.

Involuntary patients may also be admitted to a secure mental health unit in limited circumstances. These are set out in section 63 of the Act. The provisions of the Act apply to an involuntary patient who has been admitted to a secure mental health unit and who has not been discharged from the unit as if the patient was a forensic patient who is not subject to a restriction order.

People who are admitted to a secure mental health unit are taken to be in the custody of the controlling authority of the secure mental health unit throughout the period of detention unless a Court order, or the Act provides otherwise. This includes while the patient is on leave or away from the secure mental health unit for an approved purpose and during any period that the patient is being detained in a secure institution, approved hospital or other place to which he or she has been transferred under relevant sections of the Act.

10.1 Admission

Under section 68 of the Act, the following people can be admitted to a secure mental health unit:

- people who are subject to restriction orders
- people who are subject to supervision orders and who are apprehended under section 31 of the Criminal Justice (Mental Impairment) Act
- people whose fitness to stand trial is reserved for investigation under the Criminal Justice (Mental Impairment) Act and who are directed by a Court under section 39(1)(b)(ii) of that Act to be detained in a secure mental health unit
- people who are subject to Assessment Orders made under section 73 of the Sentencing Act 1997 (Tas) providing for or allowing the person’s admission to and detention in a secure mental health unit
- people who are subject to orders made under section 47 of the Justices Act 1959 (Tas) committing the person to a secure mental health unit
- people who are subject to orders made under section 348 of the Criminal Code Act 1924 (Tas) committing the person to a secure mental health unit
- people who are subject to orders made under section 105 of the Youth Justice Act 1997 (Tas) remanding the person to a secure mental health unit
- people who are subject to any other orders of a Court under the Criminal Justice (Mental Impairment) Act, Criminal Code Act, Justices Act, Sentencing Act or Youth Justice Act remanding or committing the person to or in a secure mental health unit, or otherwise requiring the person to be detained in a secure mental health unit
- prisoners and whose removal from a prison to a secure mental health unit has been directed under section 36A(2) or (3) of the Corrections Act 1997 (Tas), and
- youth detainees whose removal from a detention centre to a secure mental health unit has been directed under sections 134A(2) or (3) of the Youth Justice Act.

Section 70 of the Act applies to prisoners and youth detainees who have been removed from prison or youth detention to a secure mental health unit on the prisoner or youth detainee’s own request.
Section 70 confirms that a prisoner or youth detainee who has been removed to a secure mental health unit on this basis may ask to be returned to the custody of the Director of Corrective Services or Secretary (Youth Justice) at any time. The CFP is required to have the patient examined by an AMP as soon as possible after receiving such a request and following this, may either agree to or refuse the request.

10.1.1 Admission of Involuntary Patients

The Act also provides for the admission of involuntary patients who are not also prisoners or youth detainees to secure mental health units. The circumstances and way in which this may occur are narrow and are set out in section 63 of the Act.

Under section 63 of the Act, an involuntary patient may only be admitted to a secure mental health unit if:

- the involuntary patient is, immediately prior to admission, being detained in an approved hospital
- the admission is authorised by the CFP or a delegate following a formal request from the CCP for this to occur. To authorise the admission, the CFP must be satisfied that:
  - the involuntary patient is a danger to himself or herself or to others, because of mental illness
  - the danger is, or has become so serious as to make the involuntary patient’s continued detention in the approved hospital untenable
  - a secure mental health unit is, in the circumstances the only appropriate place where the involuntary patient can be safely detained, and
  - the secure mental health unit to which admission is contemplated has the resources to give the involuntary patient appropriate treatment and care.

If the involuntary patient is a child, the CFP must also be satisfied that the involuntary patient can be detained separately from adults and that the probable benefits of accommodating the involuntary patient in a secure mental health unit outweigh the probable risks.

Under section 64 of the Act, the CFP is required to determine the period for which the involuntary patient may be detained. The CFP may extend the period of detention, in consultation with the CCP. The Act requires notice of the admission, and any extension of the period of admission, to be given to the involuntary patient and other relevant people.

The CFP is also required to ask the CCP to arrange for the involuntary patient to be returned to an approved hospital if, at any, the CFP comes to be satisfied that the involuntary patient no longer meets the requirements of admission. The Act requires the CCP to agree to any such transfer request that is made.

10.2 Duration of Detention

10.2.1 Forensic Patients Generally

The period for which a person may be detained in a secure mental health unit as a forensic patient are set out in section 69 of the Act as follows:

- patients who are subject to restriction orders may be detained until the order is discharged. Restriction orders are indefinite in nature and for some people this may mean indefinite detention
- people who are subject to supervision orders and who have been apprehended under section 31 of the Criminal Justice (Mental Impairment) Act may be detained until the end of the period allowed under section 31 of that Act
- if the person is subject to an order of the Court, he or she may be detained until the order ends.
10.2.2 Prisoners

Prisoners who have been admitted to the secure mental health unit following a direction under section 36A of the Corrections Act may be detained until whichever of the following events occurs first:

- the end of the period specified in the direction authorising the person’s admission to the secure mental health unit, or in any agreement made under section 36A
- the end of the 48-hour period after the CFP has asked the Director of Corrective Services to remove the person from the secure mental health unit following a determination under section 36A that the person would no longer benefit from being in the secure mental health unit
- the end of the 48-hour period after the CFP has decided that it would be appropriate for a person whose admission to a secure mental health unit was requested by him or her to be returned to the custody of the Director of Corrective Services
- the person is released on parole
- if the person is a detainee within the meaning of the Corrections Act, until the order remanding or otherwise omitting him or her to prison ends
- the person completes his or her sentence of imprisonment.

10.2.3 Youth Detainees

Youth detainees who have been admitted to the secure mental health unit following a direction under section 134A of the Youth Justice Act may be detained until whichever of the following events occurs first:

- the end of the period specified in the direction authorising the youth detainee’s admission to the secure mental health unit
- the end of the 48-hour period after the CFP has asked the Secretary (Youth Justice) to remove the person from the secure mental health unit following a determination under section 134A that the person would no longer benefit from being in the secure mental health unit
- the end of the 48-hour period after the CFP has decided that it would be appropriate for a person whose admission to the secure mental health unit was requested by him or her to be returned to the custody of the Secretary (Youth Justice)
- the person is released from detention on a supervised release order made under the Youth Justice Act
- if the person has not been sentenced for the offence in respect of which he or she is being detained, until the order remanding or otherwise committing him or her to a detention centre ends
- the person completes his or her sentence of imprisonment.

10.2.4 Involuntary Patients

An involuntary patient who has been admitted to a secure mental health unit under section 63 of the Act may be detained in the unit until whichever of the following events occurs first:

- the end of the period of detention that has been determined or extended by the CFP under section 64 of the Act
- the end of the 24 period after the CFP has asked the CCP to arrange for the person to be returned to an approved hospital under section 64 of the Act
- any Assessment Order or Treatment Order to which the person is subject expires or is discharged.
10.3 Patient Movements

10.3.1 Transfer Between Secure Mental Health Units
The CFP may direct the transfer of a forensic patient from one secure mental health unit to another. The circumstances and way in which this may occur are set out in section 72 of the Act.

Tasmania only has one secure mental health unit and as such, section 72 is not utilised.

10.3.2 Transfer to Hospital Etc
The CFP may direct the transfer of a forensic patient from a secure mental health unit to a secure institution, approved hospital, a health service within the meaning of the Health Complaints Act 1995 (Tas) or premises from which a health service is provided.

The circumstances and way in which this may occur are set out in section 73 of the Act.

Section 73 is commonly used in practice to facilitate medical and allied health appointments for forensic patients.

10.3.3 Return of Patients to Secure Mental Health Units
Section 74 applies to the return of certain forensic patients who have absconded from custody, who have failed to comply with the terms and conditions of leave that has been granted, or whose leave from the secure mental health unit has expired while they are still on leave, and who are still in Tasmania.

Forensic patients who are subject to restriction orders are not included in the scope of section 74 because the return of this category of patient is provided for in the Criminal Justice (Mental Impairment) Act.

Section 75 applies to the return of certain forensic patients who are believed to no longer be in Tasmania to the State by way of a warrant issued by a Magistrate.

Forensic patients who are subject to an order of detention issued under the Criminal Justice (Mental Impairment) Act, or to a Treatment Order made by a Court are not included in the scope of section 75 because the return of this category of patient is provided for in the Criminal Justice (Mental Impairment) Act.

10.3.4 Leave of Absence
Leave of absence for forensic patients who are subject to restriction orders is provided for in sections 77 - 80 of the Act while leave of absence for forensic patients who are not subject to restriction orders, and involuntary patients who have been admitted to a secure mental health unit under section 63 of the Act, is provided for in sections 81 – 84 of the Act.

In each case, leave may be granted for personal reasons, or clinical reasons.

Under the Act, personal reasons (for granting a forensic patient leave of absence) include visiting a sick or dying relative or close friend, attending a relative or close friend’s funeral, wedding or graduation, or attending a special religious event or service.

Under the Act clinical reasons (for granting a forensic patient leave of absence) include facilitating the patient’s rehabilitation or reintegration to the community, furthering the patient’s treatment, and reasons deemed appropriate by the person authorised to grant the leave.
10.3.5 Attendance at Court

Processes for bringing forensic patients before Courts are set out in section 116 of the Act.

Under section 116, a judge, associate judge, magistrate or justice may order the controlling authority of a secure mental health unit to:

- bring a forensic patient who has been charged with a new offence before the Court specified in the order to be dealt with according to law, or
- bring a forensic patient before the judge, associate judge, magistrate or justice to give evidence.

The judge, associate judge, magistrate or justice is required to consider advice from the CFP or a medical practitioner on the patient’s fitness and the impact that an order issued under section 116 of the Act is likely to have on the patient’s health or safety.

Processes for enabling a forensic patient to attend the taking of a deposition of a person who is dangerously ill and unable to travel are in turn set out in section 117 of the Act. A deposition may be understood in this context as a pre-trial oral examination.

As with orders issued under section 117 of the Act, before a judge, associate judge, magistrate or justice makes a request to the controlling authority of a secure mental health unit to allow a forensic patient to leave the secure mental health unit to attend the taking of a deposition the judge, associated judge, magistrate or justice is required to consider advice from the CFP or a medical practitioner on the patient’s fitness and the impact that a request made under section 117 is likely to have on the patient’s health or safety.

10.3.6 Leave for Forensic Patients Subject to Restriction Orders

Under the Act, the MHT has responsibility for granting a forensic patient who is subject to a restriction order leave of absence in Tasmania.

The MHT may grant a forensic patient who is subject to a restriction order leave of absence in Tasmania for clinical reasons or personal reasons.

Leave for clinical reasons may only be applied for by the CFP while leave for personal reasons may be applied for by the patient, the CFP, or a person who the CFP thinks has a genuine interest in the patient’s welfare. The Act requires help to be given to a patient who seeks to apply for leave.

The Act imposes certain obligations on the MHT and others once an application has been made. In particular:

- The MHT is to notify the Secretary (Corrections) of the application. The Secretary (Corrections) is then to check the Eligible Persons Register to determine whether there are any eligible persons (registered victims) in relation to the patient. If there are, the Secretary (Corrections) is required to make a reasonable attempt to notify each eligible person of the application and of their right to make written submissions in respect of it. Each eligible person then has 10 days in which to make a submission.
- The MHT is to notify any other person who the MHT thinks should be told about the application and of that person’s right to make written submission in respect of it. Any person notified in this way then has 10 days in which to make a submission.
- The MHT is to consider any submissions received before granting or refusing to grant the request for leave.
The MHT can grant leave for a particular purpose, for a specified period, or for a particular purpose and period. If leave is granted for a particular purpose without a period being specified, then the period may be determined by the CFP.

The MHT may also grant leave subject to conditions including that the patient is under escort during the leave.

Leave that has been granted may be extended or varied by the MHT. The requirements and obligations on the MHT that apply to applications also apply to extensions and variations.

Any application for extension of leave must be lodged at least 20 days before the leave that has been granted expires. This is to provide enough time for the Secretary (Corrections) and any eligible persons to be notified and for submissions to be made.

Leave may also be cancelled. This may occur at any time and can be actioned by either the MHT or by the CFP, the controlling authority of the secure mental health unit, the Secretary, Department of Health, the patient’s treating medical practitioner or any AMP.

10.3.7 Leave for Forensic Patients Not Subject to Restriction Orders

Under the Act, the CFP is responsible for granting forensic patients who are not subject to restriction orders leave of absence in Tasmania. This includes involuntary patients who have been admitted to a secure mental health unit under section 63 of the Act.

The CFP may grant a forensic patient who is subject to a restriction order leave of absence in Tasmania for clinical reasons or personal reasons. Leave for clinical reasons may be applied for by the patient’s treating medical practitioner while leave for personal reasons may be applied for by the patient or a person who the CFP thinks has a genuine interest in the patient’s welfare. The Act requires help to be given to a patient who seeks to apply for leave.

The Act imposes certain obligations on the CFP and others once an application has been made. In particular:

- The CFP is to notify the Secretary (Corrections) of the application. The Secretary (Corrections) is then to check the Eligible Persons Register to determine whether there are any eligible persons (registered victims) in relation to the patient. If there are, the Secretary (Corrections) is required to make a reasonable attempt to notify each eligible person of the application and of their right to make written submissions in respect of it. Each eligible person then has 10 days in which to make a submission.

- If the patient is a prisoner or detainee under the Corrections Act, the CFP is to notify the Director, Corrective Services of the application and of the Director’s right to make a written submission in respect of the application. The Director then has 10 days in which to make a submission.

- If the person is a youth detainee, the CFP is to notify the Secretary (Youth Justice) of the application and of the Secretary’s right to make a written submission in respect of it. The Director then has 10 days in which to make a submission. The CFP is also to check whether the Secretary consents to the application. This is relevant because the CFP may only grant leave to a person who is a youth detainee if the Secretary consents.

- The CFP is to notify any other person who the CFP thinks should be told about the application and of that person’s right to make written submission in respect of it. Any person notified in this way then has 10 days in which to make a submission.

- The CFP is to consider any submissions received before granting or refusing to grant the request for leave.
These obligations do not apply to involuntary patients who have been admitted to a secure mental health unit under section 63 of the Act. This is because the eligible persons register applies only to prisoners who have been sentenced to a period of imprisonment for a violent offence, family violence offence or a sexual offence, adult forensic patients who are subject to restriction orders or family violence orders, and forensic patients who are subject to supervision orders who have been apprehended under section 31 of the Criminal Justice (Mental Impairment) Act in respect of a violent offence, family violence offence or a sexual offence and a person can only register as an eligible person in respect of prisoners and forensic patients falling into these categories.

The CFP can grant leave for a particular purpose, for a specified period, or for a particular purpose and period. If leave is granted for a particular purpose without a period being specified this may be determined by the patient’s treating medical practitioner.

The CFP may also grant leave subject to conditions including that the person is under escort during the leave.

Leave that has been granted may be extended or varied by the CFP. The requirements and obligations on the CFP that apply to applications also apply to extensions and variations, including the requirement for any extension or variation of leave for a person who is a youth detainee to take place only with consent of the Secretary (Youth Justice).

Any application for extension of leave must be lodged at least 20 days before the leave that has been granted expires. This is to provide enough time for the Secretary (Corrections) and any eligible persons and other relevant persons to be notified and for submissions to be made.

Leave may also be cancelled. This may occur at any time and can be actioned by either CFP, the controlling authority of the secure mental health unit, the person’s treating medical practitioner or any AMP.

10.3.8 Notice to Eligible Persons

The Act imposes special obligations under sections 80 and 84 on the controlling authority of a secure mental health unit with respect to eligible persons.

The controlling authority may only allow a forensic patient who has been granted leave to take the leave if the controlling authority has notified the Secretary (Corrections) and ensured that either the Secretary (Corrections) has notified each eligible person in relation to the leave and the terms of the leave, or that circumstances have made it impossible, impracticable or inappropriate for the Secretary (Corrections) to give notice in a particular case.

The Act also imposes obligations on the Secretary (Corrections) to make a reasonable attempt to notify each eligible person of any extension, variation or cancellation of leave of absence that has been granted in relation to relevant forensic patients.

These obligations do not apply to involuntary patients who have been admitted to a secure mental health unit under section 63 of the Act for the reasons outlined above.
The Act also makes it a requirement under section 119 of the Act for the controlling authority of a secure mental health unit to notify the Secretary (Corrections) when a forensic patient is finally released from a secure mental health unit (or transferred to another secure mental health unit). This is to enable the Secretary (Corrections) to search the eligible persons register and let each eligible person in relation to the forensic patient know of his or her release or transfer.

**Question 16:**
Are provisions for forensic patient movements and forensic patient leave operating effectively and efficiently? Are they clear and easy to understand?

### 10.4 Treatment

#### 10.4.1 Treatment under a Treatment Order

An involuntary patient who has been admitted to a secure mental health unit under section 63 of the Act may be treated under the authority of any subsisting Treatment Order and the Treatment Order has effect as if it provided for the involuntary patient’s detention in the secure mental health unit.

It is occasionally necessary to renew a Treatment Order to which an involuntary patient is subject, while the patient is being detained in a secure mental health unit. The ability to renew a Treatment Order in these circumstances and the circumstances in which this may occur are set out in section 65A of the Act.

#### 10.4.2 Authorisation of Treatment by the Tribunal

The MHT may authorise treatment for a forensic patient if satisfied of the matters outlined in section 88 of the Act. These include that:

- the person has a mental illness
- without treatment, the mental illness will, or is likely to, seriously harm the person’s health or safety or the safety of others
- the treatment will be appropriate and effective in terms of the treatment outcomes referred to in the meaning of treatment set out in section 6 of the Act, and
- the person does not have decision-making capacity.

This is largely reflective of the treatment criteria that would need to be met for the MHT to make a Treatment Order.

The Act requires the MHT to determine an application for treatment for a forensic patient via a hearing conducted before a division of at least three MHT members.

The MHT may authorise treatment for a forensic patient conditionally, or unconditionally with any conditions to be set out in a written authorisation which has effect according to its terms.

Under section 93 of the Act, the MHT may discharge an authorisation that has been given at any time while the person is a forensic patient (that is, at any time before the person is discharged from the secure mental health unit).

#### 10.4.2.1 Interim Authorisation of Treatment

Under section 91 of the Act, a single member of the MHT may authorise treatment for a forensic patient if the member is satisfied that the criteria that the MHT must be satisfied of in section 88 to authorise treatment are met, that the MHT cannot immediately determine the application, and that achieving the
necessary treatment outcomes would be compromised by waiting for the treatment to be authorised by the MHT under section 88 of the Act.

The MHT member may authorise the treatment on the application alone, and without any hearing or further investigation.

As with treatment that is authorised under section 88, the treatment may be authorised conditionally or unconditionally with any conditions to be set out in a written authorisation which has effect according to its terms.

Interim authorisation may be revoked or varied at any time but otherwise continues in effect according to its terms until the MHT considers the original application by way of a hearing.

An application for authorisation of treatment for a forensic patient lapses after 14 days if the MHT has not determined it by then.

10.4.2.2 Authorisation Becomes a Treatment Order

Authorisation that is given for a forensic patient is taken to be a Treatment Order of six months duration on and from the day of the person’s discharge from the secure mental health unit, unless the Treatment Order is discharged or otherwise ceases to be in effect.

Question 17:
Are provisions for the treatment of forensic patients operating effectively and efficiently? Are they clear and easy to understand?

10.5 Management

10.5.1 Use of Force

The Act limits the circumstances in which force may be used with respect to forensic patients.

Under section 93, force may only be applied to a forensic patient if the force is necessary to address physical violence, resistance or disturbance of the patient and is applied:

- to facilitate the forensic patient’s treatment or general health care
- to ensure the forensic patient’s health or safety or the safety of others
- to prevent the forensic patient from destroying or damaging property
- to prevent the forensic patient’s escape from lawful custody
- to provide for the good management, good order or security of the secure mental health unit
- to facilitate the forensic patient’s lawful transfer to or from another facility, whether in Tasmania or elsewhere
- for a reason sanctioned by Chief Forensic Psychiatrist Standing Orders, or
- to place the forensic patient in seclusion or under restraint.

Force is only to be used by a member of secure mental health unit staff, a medical practitioner, a nurse, an authorised person or a person who has or is entitled to take immediate lawful custody of the forensic patient, or an assistant of one or more of these people.
The force used may be no more excessive, unusual or prolonged than is reasonably justified in the circumstances and in no case may force be applied as a means of punishment or for reasons of administrative or staff convenience.

Under section 96 of the Act, any use of force is to be recorded.

10.5.2 Entry of Items to the Secure Mental Health Unit

It is an offence under section 113 of the Act for a person to bring an item that the CFP has not authorised to be brought or sent into a secure mental health unit, into such a unit. A person who is found to have brought such an item into a secure mental health unit may be detained until the person can be arrested by a police officer.

The items that the CFP has not authorised to be brought or sent into a secure mental health unit are set out in Chief Forensic Psychiatrist Standing Order 17, which can be accessed online here: www.dhhs.tas.gov.au/__data/assets/pdf_file/0003/252777/CFP_Standing_Order_17_-_Unauthorised_Items_FINAL.pdf

10.5.3 Screens and Searches

Powers related to screening processes for people seeking entry to a secure mental health unit, and for searches, are set out in sections 110 and 111 of the Act respectively.

Under section 110 of the Act, the CFP or the controlling authority of a secure mental health unit may require any person, including police officers, health practitioners and others, who is seeking entry to a secure mental health unit to have their body, clothes or belongings screened using remote or non-intrusive technical devices such as metal detectors, sensors and X-ray scanners. The CFP or controlling authority may also refuse to allow a person who fails to comply with a requirement to be screened entry to the unit.

Under section 111 of the Act, the CFP or the controlling authority of a secure mental health unit may authorise or direct an authorised person to carry out a search. This may be a manual search or involve the use of animal detection or electronic or mechanical methods. This can be for the management, good order or security of the unit or for the safety of any people in the unit and may be of:

- any part of the unit or anything in the unit, and anything in the unit's immediate precincts
- anything being delivered to or removed from the unit or any vehicle or other thing that is being used in connection with the delivery or removal
- any forensic patient, visitor, staff member or other person in the unit or in the unit’s immediate precincts
- clothing, personal belongings, physical aids, containers or any thing in or under the possession or control of a forensic patient, visitor, staff member of other person in the unit or in the unit’s immediate precincts, or
- information held on a computer, mobile phone or other device.

An authorised person who carries out a search may use the force, methods and assistance as he or she considers to be reasonably necessary and may ask, and require answers on, the source, identity, nature, purpose, properties and contents of anything that is found.

Certain searches may be conducted without consent, and people other than forensic patients or secure mental health unit staff members who refuse to submit to or who hinder a search may be directed to leave
the unit. A person who fails to comply with a direction to leave the unit in these circumstances is guilty of an offence and may be detained until he or she can be arrested by a police officer.

Searches that involve touching a person, require a person to undress, or involve any touching of a person’s clothes or personal belongings must be carried out under section 111 in privacy and by an authorised person of the same gender as the person being searched, and only in the presence of people of that gender.

An authorised person may seize items found during a search conducted under section 111 of the Act. The circumstances in which this may occur and the steps that the authorised person must take following the seizure are set out in section 112 of the Act.

Chief Forensic Psychiatrist Standing Order 16 provides detailed guidance with respect to screens and searches. Standing Order 16 can be found online here: www.dhhs.tas.gov.au/__data/assets/pdf_file/0011/252776/CFP_Standing_Order_16_-_SMHU_Screen_and_Search.pdf

Question 18:
Are provisions for the management of forensic patients and the secure mental health unit operating effectively and efficiently? Are they clear and easy to understand?

10.6 Forensic Patient Rights

The Act seeks to achieve a consumer-centred, rights-based framework for assessment and treatment of people with mental illness.

In particular, the Act does not enable a person with decision making capacity to be assessed, treated or detained against their will. The Act also makes decision-making capacity a criterion for determining whether the legislation applies.

The Act’s objects include to:

• provide for the assessment and treatment of people with mental illness to be given in the least restrictive setting consistent with clinical need, legal and judicial constraints, public safety and patient health, safety and welfare, and

• promote voluntary over involuntary assessment and treatment and the making of free and informed assessment and treatment choices.

The Act also requires people exercising responsibilities under the legislation to have regard to principles, including to:

• respect, observe and promote the inherent rights, liberty, dignity, autonomy and self-respect of people with mental illness

• interfere with or restrict the rights of people with mental illness in the least restrictive way and to the least extent consistent with the protection of those persons, the protection of the public and the proper delivery of the service, and

• promote the ability of people with mental illness to make their own choices.

The Act also provides forensic patients with certain specific rights, including:

• The visiting, telephone and correspondence rights set out in sections 97 – 107 of the Act.

• The right to be given a written statement that set out and explains the rights that a forensic patient has in key circumstances (a Statement of Rights), and other important documentation, at various points throughout the patient’s admission and treatment pathway.
• The right to ask the CFP to intervene directly regarding the patient’s assessment, treatment or care. This right is set out in section 147 of the Act.

• The right, as a person with standing, apply to the MHT to review certain matters. These rights are set out in Part 3 Division 2 of the Act.

• The right to apply to the MHT, as a person with standing, for an Order, determination, direction, or other document to be corrected. This right is set out in section 224A of the Act.

• The right to have information given to him or her in a language or form that the person understands, using an interpreter or alternative augmentative communication system if necessary. This right is set out in section 135 of the Act.

• The further rights set out in section 108 of the Act.

The circumstances in which a forensic patient is required to be given a Statement of Rights, and the further rights that forensic patients have under section 108 of the Act, are set out in full at Appendix 7.

10.6.1 Visiting, Telephone and Correspondence Rights

The Act provides forensic patients with certain visiting, telephone and correspondence rights. These are provided for in sections 97 – 107 of the Act.

Provisions of the Act that deal with visiting, telephone and correspondence rights refer to privileged visitors, callers and correspondents. These are visitors, callers and correspondents with status under the Act or other laws and include people such as the Chief Psychiatrists, Official Visitors and members and staff of the MHT. A full list is set out in section 98 of the Act.

The Act’s provisions relating to visiting, telephone and correspondence rights are modified in their application to privileged visitors, callers and correspondents as follows:

• Section 101 of the Act, which enables the CFP, the controlling authority of a secure mental health unit or an authorised person to require a visitor to explain the nature of the person’s relationship to any forensic patient in the secure mental health unit and the purpose of the visit, and to provide other relevant information, does not apply to privileged visitors.

• The circumstances in which telephone calls to or from privileged callers may be refused under section 106 are different to the circumstances that apply to telephone calls to or from callers who are not privileged callers.

• The information that a privileged caller may be required to provide under section 106 when making a call to a forensic patient is more limited than the information that a caller other than a privileged caller may be required to provide.

• The circumstances in which mail to or from privileged correspondents may be refused under section 107 are different to the circumstances that apply to mail to or from correspondents who are not privileged correspondents.

• The ability under section 107 for a forensic patient’s mail or email to be opened and read does not extend to mail sent to or from privileged correspondents.

The CFP may cancel or suspend a person’s status as a privileged visitor, privileged caller or privileged correspondent. This may occur if the CFP is satisfied on reasonable grounds that the person has engaged in behaviour that is not compatible with the management, good order or security of a secure mental health unit. The CFP’s power in this respect is set out in section 98 of the Act.

The CFP has not exercised the power available under section 98 of the Act to date.

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10.6.2 Visiting Rights

A forensic patient’s right to receive, or refuse to receive, visitors is set out in section 97 of the Act. As confirmed by that section, these rights may be exercised only in accordance with the Act.

The circumstances and way in which a person may enter a secure mental health unit as a visitor are set out in sections 99, 100, 101, 102, 103, 104 and 105 of the Act.

In summary:

- Section 99 clarifies when a person may enter a secure mental health unit as a visitor and confirms the ability for a person who enters a secure mental health unit as a visitor to be given directions.
- Section 100 relates to the requirement to provide proof of identity or status before being permitted entry to the secure mental health unit, and that this may extend to fingerprints, or other biometric data.
- Section 101 regulates the information that a visitor to a secure mental health unit may be required to provide before gaining entry to the unit.
- Section 102 confirms the circumstances in which a person must or may be refused entry to a secure mental health unit as a visitor.
- Section 103 confirms the circumstances in which a person who has entered a secure mental health unit as a visitor may be asked to leave the unit.
- Section 104 confirms that it is an offence for a person to fail to comply with a direction given under sections 99, 102 or 103, and that a visitor who fails to comply with a direction be removed from the unit or detained until such time as the person may be arrested by a police officer.

Chief Forensic Psychiatrist Standing Order 15 applies to the information that visitors are required to provide as proof of identity or status before being allowed entry to a secure mental health unit. Standing Order 15 can be found online here: [www.dhhs.tas.gov.au/__data/assets/pdf_file/0010/252775/CFP_Standing_Order_15_-_Visitor_ID.pdf](http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0010/252775/CFP_Standing_Order_15_-_Visitor_ID.pdf)

10.6.2.1 Police Visits

Police visits are regulated under section 105 of the Act with authority to allow a police visit resting with the CFP or the controlling authority of a secure mental health unit.

Section 105 provides forensic patients with certain rights in respect of police visits. These are:

- to have discussions with an Australian lawyer before the visit occurs
- to have a representative, medical practitioner, secure mental health unit staff member or other support person present
- to refuse to answer any questions, and
- to end the visit at any time.

Section 105 confirms that nothing in it is to be taken as preventing or restricting police officers from exercising other relevant powers.

10.6.3 Telephone Rights

A forensic patient’s right to make or refuse to make or receive telephone calls, text messages or other communications made using a telephone, radio or similar electronic device, and the circumstances in which this right may be exercised or refused are set out in section 106 of the Act.
The section also confirms the information that a person making or wishing to make a telephone call to the forensic patient is required to provide, which in the case of callers who are not privileged callers may include the nature of the person's relationship to the patient, the purpose of the call and other reasonable information.

### 10.6.4 Correspondence Rights

A forensic patient’s right to send or refuse to send, and receive or refuse to receive mail and email, and the circumstances in which this right may be exercised or refused, are set out in section 107 of the Act.

Under section 107, the Chief Forensic Psychiatrist, controlling authority of the secure mental health unit or an authorised person may require that any mail or email sent to or received by the forensic patient, other than mail or email sent to or by a privileged correspondent, be opened and read by an authorised person.

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<th>Question 19:</th>
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<td>Are forensic patients being afforded the rights referred to in the Act and this document? If not, why do you think this is?</td>
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11. Seclusion and Restraint

Seclusion and restraint are amongst the most restrictive interventions that can be invoked to manage the behaviour of involuntary patients and forensic patients in secure settings. The Act strictly regulates seclusion, and chemical restraint, mechanical restraint and physical restraint of involuntary patients and forensic patients for this reason.

Sections 56 and 94 of the Act regulate seclusion for involuntary patients and forensic patients while sections 57 and 95 of the Act regulate chemical, mechanical and physical restraint for involuntary patients and forensic patients.

The Act requires the Chief Psychiatrists to issue Standing Orders for seclusion and restraint, and any seclusion or restraint that is authorised is required to be managed in accordance with such Orders. The CCP and CFP have issued the following Standing Orders for seclusion and restraint:

- Chief Civil Psychiatrist Standing Order 9, which applies to the authorisation of seclusion for involuntary patients
- Chief Forensic Psychiatrist Standing Order 9, which applies to the authorisation of seclusion for forensic patients
- Chief Civil Psychiatrist Standing Order 10, which applies to the authorisation of chemical restraint for involuntary patients
- Chief Civil Psychiatrist Standing Order 10A, which applies to the authorisation of mechanical and physical restraint for involuntary patients
- Chief Forensic Psychiatrist Standing Order 10, which applies to the authorisation of chemical restraint for forensic patients
- Chief Forensic Psychiatrist Standing Order 10A, which applies to the authorisation of mechanical and physical restraint for forensic patients.

The following Clinical Guidelines have also been issued:

- Chief Civil Psychiatrist Clinical Guideline 9, which applies to the authorisation of seclusion for involuntary patients
- Chief Forensic Psychiatrist Clinical Guideline 9, which applies to the authorisation of seclusion for forensic patients
- Chief Civil Psychiatrist Clinical Guideline 10, which applies to the authorisation of chemical restraint for involuntary patients
- Chief Civil Psychiatrist Clinical Guideline 10A, which applies to the authorisation of mechanical and physical restraint for involuntary patients
- Chief Forensic Psychiatrist Clinical Guideline 10, which applies to the authorisation of chemical restraint for forensic patients
- Chief Forensic Psychiatrist Clinical Guideline 10A, which applies to the authorisation of mechanical and physical restraint for forensic patients.

The Standing Orders and Clinical Guidelines expand on the circumstances in which an involuntary patient or forensic patient may be secluded or restrained, and how this is to occur. They are designed to ensure that seclusion and restraint is used minimally, and that when it is used it is used appropriately, safely and in a way that respects the dignity and rights of patients.

11.1 Seclusion

The Act defines seclusion to mean:

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

11.1.1 Authorisation of Seclusion

The Act regulates seclusion for involuntary patients and forensic patients as follows:

- under section 56 of the Act, an involuntary patient may only be placed in seclusion if the person is in an approved hospital and if:
  - the seclusion is authorised as being necessary to facilitate the person’s treatment, to ensure the person’s health or safety, to ensure the safety of other people or to provide for the management, good order or security of the approved hospital
  - the seclusion is authorised by:
    - if the person is a child, the CCP or a delegate
    - if the person is an adult, the CCP or a delegate, or a medical practitioner, or an approved nurse
  - the person authorising the seclusion is satisfied that it is a reasonable intervention in the circumstances, and
  - the seclusion lasts for no longer than has been authorised.

- under section 94 of the Act, a forensic patient may only be placed in seclusion if:
  - the seclusion is authorised as being necessary to facilitate the person’s treatment or general health care, to ensure the person’s health or safety or the safety of others, to prevent the person from destroying or damaging property, to prevent the person’s escape from lawful custody, to provide for the management, good order or security of the secure mental health unit, to facilitate the person's lawful transfer to or from another facility, whether in Tasmania or elsewhere, or for a reason sanctioned by Chief Forensic Psychiatrist Standing Orders
  - the seclusion is authorised by:
    - if the person is a child, the CFP or a delegate
    - if the person is an adult, the CFP or a delegate, or a medical practitioner, or an approved nurse
  - the person authorising the seclusion is satisfied that it is a reasonable intervention in the circumstances, and
  - the seclusion lasts for no longer than has been authorised.

Under Standing Order 9, the decision to seclude a forensic patient may only be made after less restrictive interventions and de-escalation techniques have been tried without success, or when these have been considered but excluded as inappropriate or unsuitable in the circumstances and following a full risk assessment. Seclusion may only also be authorised to provide for the management, good order or security
of an approved hospital when this is necessary to prevent significant damage to property and/or ensure the health and safety of the patient, staff members, other patients, or visitors. One-to-one one nursing care should be considered if the person is suicidal.

The Act confirms that involuntary patients and forensic patients may never be secluded as a means of punishment or for administrative or staff convenience. This prohibition is expanded in the Chief Psychiatrists Standing Orders which prevent seclusion from being applied to compensate for or overcome inadequate facility design or insufficient staffing.

The authorisation and documentation requirements associated with seclusion are set out in section 58 of the Act for involuntary patients and in section 96 of the Act for forensic patients. These requirements are further expanded upon in the Standing Orders. In summary:

- authorisation is to be given at the time that the decision to seclude a patient is made. It may not be given in advance or retrospectively or be given conditional upon certain events occurring
- authorisation may be given over the phone but only if:
  - the person giving the authorisation is satisfied that the patient meets the criteria to be secluded within the parameters set by the Act, based on information that has been given to him or her by members of nursing staff who are with the patient at the time the authorisation is sought, and
  - there is nobody else who could authorise the patient's seclusion in person in a reasonable timeframe, and
- the person authorising seclusion must make a record of this and give a copy of the record to the patient and to others.

### 11.1.2 Duration of Seclusion

The Act and Standing Orders jointly set limits on the duration of a person's seclusion.

Under the Standing Orders an involuntary patient may only be secluded for an initial period of three hours, with the Chief Psychiatrist or delegate's approval required for continuation of seclusion that has been authorised to provide for the management, good order or security of the relevant facility for a period of more than 30 minutes. Any extension of seclusion is to be for a period of three hours or less. The Act in turn requires every extension of seclusion beyond seven hours to occur only if the person has been examined by a medical practitioner within the first seven hours and if the extension (and any subsequent extension) has been authorised by the relevant Chief Psychiatrist. Any extension that is granted may be subject to conditions.

In no case may seclusion continue for longer than the period that has been authorised or be continued where this is obviously detrimental to the person’s mental or physical health.

### 11.2 Restraint

The Act defines restraint to mean any form of chemical, mechanical or physical restraint.

The Act in turn defines chemical restraint, mechanical restraint and physical restraint as follows:

- **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.
11.2.1 Authorisation of Restraint

The Act regulates restraint for involuntary patients and forensic patients as follows:

- under section 57 of the Act, an involuntary patient may only be placed under restraint if the patient is in an approved assessment centre or approved hospital and if:
  - the restraint is authorised as being necessary to facilitate the person’s treatment, to ensure the person’s health or safety, to ensure the safety of other people or to bring about the person’s transfer to another facility
  - the restraint is authorised by:
    - if the restraint is chemical restraint or mechanical restraint, the CCP or a delegate
    - if the restraint is physical restraint and the person is a child, the CCP or a delegate
    - if the restraint is physical restraint and the person is an adult, the CCP or a delegate, or a medical practitioner, or an approved nurse
  - the person authorising the restraint is satisfied that it is a reasonable intervention in the circumstances
  - the restraint lasts for no longer than has been authorised, and
  - if the restraint is mechanical restraint, the means of restraint to be used has been approved in advance by the CCP.

- under section 95 of the Act, a forensic patient may only be placed under restraint if:
  - the restraint is authorised as being necessary to facilitate the patient's treatment or general health care, to ensure the patient’s health or safety or the safety of others, 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, or for a reason sanctioned by Chief Forensic Psychiatrist Standing Orders
  - the restraint is authorised by:
    - if the restraint is chemical restraint or mechanical restraint, the CFP or a delegate
    - if the restraint is physical restraint and the person is a child, the CFP or a delegate,
    - if the restraint is physical restraint and the person is a child, the CFP or a delegate, or a medical practitioner, or an approved nurse
  - the person authorising the restraint is satisfied that it is a reasonable intervention in the circumstances
  - the restraint lasts for no longer than has been authorised, and
  - if the restraint is mechanical restraint, the means of restraint to be used has been approved in advance by the CFP.

The former Chief Civil Psychiatrist Dr Leonard Lambeth approved the use of “Posey” brand restraint cuffs, model number JT Posey REF 2790 L9118M, and restraint cuffs that are of a similar style and quality, as means of restraint which may be employed in specific cases of mechanical restraint under and for the purposes of section 57 of the Act on 14 February 2014. The approval took effect on 17 February 2014 and remains in place.
The then Acting Chief Forensic Psychiatrist Professor Ken Kirkby approved the use of Hiatts handcuffs serial number 241092 and Smith & Wesson handcuffs serial numbers P11302 and P66374 as means of restraint which may be employed in specific cases of mechanical restraint under and for the purposes of section 95 of the Act on 5 June 2018. The approval remains in place.

Under the Chief Psychiatrists Standing Orders 10 and 10A, the decision to restrain a patient may only be made after less restrictive interventions and de-escalation techniques have been tried without success, or when these have been considered but excluded as inappropriate or unsuitable in the circumstances and following a full risk assessment.

The Act confirms that involuntary patients and forensic patients may never be restrained as a means of punishment or for administrative or staff convenience. This prohibition is expanded in the Chief Psychiatrists Standing Orders which prevent an involuntary patient and forensic patient from being restrained to compensate for or overcome inadequate facility design or insufficient staffing. The Standing Orders also confirm that in no case may a person be both mechanically restrained and secluded.

The authorisation and documentation requirements associated with restraint are set out in section 58 of the Act for involuntary patients and in section 96 of the Act for forensic patients. These requirements are further expanded upon in the Standing Orders. In summary:

- authorisation is to be given at the time that the decision to restrain a person is made. It may not be given in advance or retrospectively or be given conditional upon certain events occurring
- authorisation may be given over the phone but only if:
  - the person giving the authorisation is satisfied that the person meets the criteria to be restrained within the parameters set by the Act, based on information that has been given to him or her by members of nursing staff who are with the person at the time the authorisation is sought, and
  - there is nobody else who could authorise the person's restraint in person in a reasonable timeframe, and
- the person authorising restraint must make a record of this and give a copy of the record to the person and to others.

### 11.2.2 Duration of Restraint

The Act and Standing Orders jointly set limits on the duration of a person’s restraint.

In the case of chemical restraint, a person may only be subject to extended chemical restraint if the person has been examined by a medical practitioner within seven hours of the restraint commencing and the restraint may continue beyond this period only if the continuation has been recommended by a medical practitioner and authorised by the relevant Chief Psychiatrist or a delegate, in advance.

In the case of mechanical restraint to transport a person from one approved facility to another, the period authorised may not exceed seven hours, with any period of extension similarly limited to a period of no more than seven hours. In all other cases of mechanical restraint, and all cases of physical restraint, the period authorised may not exceed three hours with any period of extension similarly limited to a further three hours.

In no case may restraint continue for longer than the period that has been authorised or be continued where this is obviously detrimental to the person’s mental or physical health.
11.3 Matters in Common

The observation, record keeping and other aspects of the seclusion and restraint provisions for involuntary patients and forensic patients are very similar, as outlined below.

11.3.1 Observation and Examination Requirements

Under the Act and Standing Orders, involuntary patients and forensic patients who are secluded or restrained must be:

- clinically observed by members of the facility’s nursing staff at least every 15 minutes. Observation must be direct and in person. In the case of the seclusion of children and other vulnerable people, and for all types of restraint, observation must be continuous. The focus of the observation must be on the person’s safety and dignity and any change in the person’s physical or mental status
- examined by a medical practitioner or approved nurse at least every four hours. The purpose of the examination is to see if the seclusion or restraint should continue or stop
- examined by an AMP at least every 12 hours.

The Act confirms that medications that have been prescribed to the person who is under seclusion or who has been restrained must be administered without unreasonable delay and the person must be provided with physical aids, and communication aids that the person uses to communicate on a daily basis, unless if it is strictly necessary for the person’s safety or to preserve the aids for the person’s future use, to deprive the person of access to them.

Suicide gowns (also known as anti-suicide smocks or safety smocks) must not be used on people who are secluded.

A person who has been secluded or restrained must be provided with:

- suitable clean clothing and bedding
- adequate food and drink, toilet and sanitary arrangements and air and light, and
- a way of calling for help.

Under the Act, an involuntary patient’s seclusion may not be considered to have been interrupted or stopped through compliance with a requirement to observe or examine a patient who is in seclusion, or through the giving of any necessary treatment or general health care to the patient. This is to ensure that the requirements in the Act for observation and examination once a person has been in seclusion for a required period are not avoided.
11.4 Emergency Short-Term Restraint

The Act does not apply to or prevent the emergency short-term physical restraint or an involuntary or forensic patient when this is done to:

- prevent the person from harming himself or herself or other people
- prevent the person from damaging or interfering with the operation of a facility or any equipment
- break up a dispute or affray (fight) involving the person
- ensure the person’s movement to or attendance at any place for a lawful purpose, if the person is uncooperative.

**Question 20:**

Are the seclusion and restraint provisions of the Act operating effectively and efficiently?
12. **Approved Facilities and Personnel**

The Act provides for approved facilities and personnel, as set out in sections 138 - 142 of the Act.

12.1 **Approved Facilities**

Under section 140 of the Act, responsibility for approving premises as hospitals, assessment centres and secure mental health units rests with the Minister for Mental Health and Wellbeing.

To issue an approval, the Minister must be satisfied of the following:

- that the premises to be approved are properly built, equipped and staffed to assess or treat relevant patients, and
- in the case of non-government premises, that the prospective controlling authority is suitable to oversee the approved facility.

Approval of government premises may be conferred on the Minister's own motion while approval of non-government premises requires an application or agreement from the prospective controlling authority.

Approvals may be conditional and for a fixed period. Approvals may also be revoked. The circumstances in which an approval may be revoked are set out in section 142 of the Act and include if standing orders, clinical guidelines or MHT guidelines are being materially or repeatedly contravened or the premises are no longer being used as an approved facility.

12.1.1 **Approved Hospitals and Assessment Centres**

Approved hospitals have relevance under the Act as placed in which involuntary patients may be detained in relevant circumstances.

Approved assessment centres have relevance under the Act as places to which a person who is in protective custody must be escorted so that the person can be examined by a medical practitioner to see if he or she needs to be assessed against the assessment criteria or the treatment criteria.

Premises may only be approved as hospitals or assessment centres under section 140 of the Act if they are considered by the Minister for Mental Health and Wellbeing to be properly built, equipped and staffed to assess or treat involuntary patients with mental illness.

There are five approved hospitals in Tasmania:

- Royal Hobart Hospital
- Launceston General Hospital
- North West Regional Hospital
- Roy Fagan Centre, and
- Millbrook Rise Centre.

Each approved hospital is also an approved assessment centre.

In each case the entire premises, including emergency departments, paediatric units and general medical wards as well as psychiatric units has been approved to assess or treat involuntary patients with mental illness.

Each of the facilities was approved in 2007 by the then Minister for Health and Human Services the Hon Larissa Tahireh Giddings MP under authority of the *Mental Health 1996* (Tas). Each is an approved hospital.
and approved assessment centre for the Act by virtue of section 4 of the Mental Health (Transitional and Consequential Provisions) Act 2013 (Tas).

12.1.2 Secure Mental Health Units

Secure mental health units are premises that are designed to assess or treat forensic patients. This includes people who are subject to restriction orders and people who are subject to supervision orders and who are apprehended under section 31 of the Criminal Justice (Mental Impairment) Act.

Premises may only be approved as secure mental health units under section 140 of the Act if they are considered by the Minister for Mental Health and Wellbeing to be properly built, equipped and staffed to assess or treat forensic patients.

Tasmania has one secure mental health unit, the Wilfred Lopes Centre.

The Wilfred Lopes Centre was approved as a secure mental health unit in January 2006 by the then Deputy Premier the Hon David Llewellyn MHA under authority of the Mental Health Act 1996 and is a secure mental health unit for the Act by virtue of section 4 of the Mental Health (Transitional and Consequential Provisions) Act.

12.2 Secure Institutions

Secure institutions are institutions other than approved hospitals, approved assessment centres or secure mental health units to which forensic patients may be transferred under the Act.

Approval of an institution as a secure institution is important because the provisions of Parts 4 and 5 of Chapter 3 of the Act apply to a forensic patient who has been transferred to a secure institution in the same way as they would do if the patient was in a secure mental health unit.

The Minister for Mental Health and Wellbeing may also approve an institution other than an approved facility as a secure institution, under section 141 of the Act.

The Hobart Reception Prison (knows as the Remand Centre) and the Launceston Reception Prison are each a secure institution for the Act.

These institutions were approved as secure institutions in January 2011 by the then Minister for Health the Hon Michelle O’Byrne MP under authority of the former Mental Health Act 1996 and are secure institutions for the Act by virtue of section 5 of the Mental Health (Transitional and Consequential Provisions) Act.

12.3 Approved Personnel

12.3.1 Approved Medical Practitioners

AMPs have significant powers and responsibilities under the Act. These include independently assessing people who are subject to Assessment Orders (and either affirming or discharging the Order), applying to the MHT for Treatment Orders, authorising urgent circumstances treatment and granting involuntary patients leave of absence from approved hospitals.

Under section 138 of the Act, the Chief Psychiatrists may approve people as medical practitioners for provisions of the Act within the Chief Psychiatrists’ jurisdiction and for provisions of other Acts under which the relevant Chief Psychiatrist has responsibilities. People who are approved are referred to in the Act as Approved Medical Practitioners or AMPs.

The Chief Psychiatrists may approve people individually. Alternatively, the Chief Psychiatrists may approve all members of a class of people.
There are limitations on who can be approved as a medical practitioner, and only people who are either psychiatrists, or medical practitioners who are otherwise qualified or experience in the diagnosis or treatment of mental illness, can be approved.

Before deciding whether to approve a person as a medical practitioner, the Chief Psychiatrists consider evidence that the person meets these criteria. This includes considering the person’s qualifications and experience and receiving confirmation from a senior clinician that knows the person that the person understands the requirements of the Act as they apply to the performance of AMP status. Every person seeking approval as a medical practitioner is also required to complete an online education and training package.

An approval takes effect when it is conferred or on a later date and remains in effect for up to five years unless it is revoked. The circumstances in which an approval may be revoked, suspended, relinquished or renewed are set out in section 138.

The Act requires each approval, and each revocation or relinquishment of an approval, to be published in the Tasmanian Government Gazette. The Gazette is available online here: www.gazette.tas.gov.au

### 12.3.2 Approved Nurses

Approved nurses have power under the Act to authorise seclusion or physical restraint for adult involuntary and forensic patients. Approved nurses are also responsible under the Act for examining people who are being secluded or restrained, and in the case of involuntary patients, performing record keeping related functions.

Under section 138 of the Act, the Chief Psychiatrists may approve people as nurses for provisions of the Act within the Chief Psychiatrists’ jurisdiction and for provisions of other Acts under which the relevant Chief Psychiatrist has responsibilities. People who are approved are referred to in the Act as approved nurses.

As with AMPs, the Chief Psychiatrists may approve people individually. Alternatively, the Chief Psychiatrists may approve all members of a class of people.

As is also the case with AMPs, there are limitations on who can be approved as a nurse, and only people who are registered nurses who are qualified or experienced in the treatment or care of people with mental illness can be approved.

An approval takes effect when it is conferred or on a later date and remains in effect for up to five years unless it is revoked. The circumstances in which an approval may be revoked, suspended, relinquished or renewed are set out in section 138.

The Act requires each approval, and each revocation or relinquishment of an approval, to be published in the Tasmanian Government Gazette. The Gazette is available online here: www.gazette.tas.gov.au

### 12.3.3 Mental Health Officers

The powers of MHOs under the Act are significant and relate to taking a person into protective custody and performing escort and transport related functions.

Under section 139 of the Act, the Chief Psychiatrist may approve people as MHOs for provisions of the Act within the Chief Psychiatrists’ jurisdiction and for provisions of the Act and for provisions of other Acts under which the relevant Chief Psychiatrists have responsibilities. People who are approved are referred to as Mental Health Officers or MHOs.

As with AMPs and approved nurses, the Chief Psychiatrists may approve people individually. The Chief Psychiatrists may also approve all members of a class of people.
As is the case with AMPs and approved nurses, there are limitations on who can be approved as an MHO, and only people who have skills, qualifications or experience relevant to the responsibilities of MHOs under the relevant provisions of the Act or other Acts, may be approved.

The Chief Psychiatrist may only approve people who are employed outside of the Department with consent of (in effect) the most senior person in the Agency in which the person is employed.

An approval takes effect when it is conferred or on a later date and remains in effect for up to five years unless it is revoked. The circumstances in which an approval may be revoked, suspended, relinquished or renewed are set out in section 138.

The Act requires each approval, and each revocation or relinquishment of an approval, to be published in the Tasmanian Government Gazette and for the MHT to be notified of each approval (or revocation or relinquishment).

The Gazette is available online here: [www.gazette.tas.gov.au](http://www.gazette.tas.gov.au)

### 12.3.3.1 Identity Cards

Section 139 of the Act requires the Chief Psychiatrists to issue each MHO (other than MHOs who are police officers or ambulance officers) with an identity card which shows that the person is an MHO.

The circumstances in which an MHO may need to provide proof of identity has been explained earlier in Chapter 8 of this document.

### 12.3.4 Authorised Persons

The powers and functions of authorised persons are set out in specific sections of the Act, and in other Acts. They relate in general terms to forensic patients and include escort and transport related functions, and functions related to the security and good order of a secure mental health unit.

Under section 109 of the Act, the CFP or the controlling authority of a secure mental health unit may authorise a person, or a member of a class of people, for the purposes of specific sections of the Act.

| Question 21: |
| Are provisions for the approval and authorisation of facilities and people operating effectively and efficiently? |
13. Information Management

Matters relating to information and information management are regulated in Part 7 of Chapter 2 of the Act.

13.1 Notifications

13.1.1 Admissions, Transfers and Discharges

Under section 130 of the Act, the controlling authority of an approved facility is required to make a reasonable attempt to notify a representative or support person of the patient or other person that the controlling authority thinks has a proper interest in the patient’s welfare of the following events:

- a patient or prospective patient’s admission or planned admission to an approved hospital or secure mental health unit
- an involuntary patient or prospective involuntary patient’s transfer or planned transfer from one approved hospital to another approved hospital or to a secure mental health unit
- a forensic patient or prospective forensic patient’s transfer or planned transfer from a secure mental health unit to another secure mental health unit, a secure institution, an approved hospital, a health service within the meaning of the Health Complaints Act or premises where a health service within the meaning of the Health Complaints Act
- a patient or prospective patient’s discharge or planned discharge from an approved hospital, a secure mental health unit, a secure institution, a health service within the meaning of the Health Complaints Act, or a place from which a health service is provided.

In the case of an impending admission, transfer or discharge, the Act requires notification to be given as far in advance as possible.

A patient or prospective patient may object to the notification being given, and notice may only be given over any objection from the patient if an AMP advises the controlling authority that the notification would be desirable having regard to the patient’s health or safety or the safety of other people, or if the MHT directs the controlling authority to do so.

13.1.2 Leave and Unlawful Absences

Under section 131 of the Act, the controlling authority is to make a reasonable attempt to notify a representative or support person of the patient, or any other person who the controlling authority thinks has a proper interest in the patient’s welfare of the following events:

- a patient’s impending leave of absence of an approved hospital or secure mental health unit
- a patient’s contravention of a condition of his or her leave of absence from an approved hospital or secure mental health
- a patient who is absent without leave or who has overstayed a leave of absence from an approved hospital or secure mental health unit.

The requirement to notify another person of a patient’s impending leave of absence applies only where the patient has not objected to this happening.
13.2 Withholding Information

Under section 132 of the Act, a Chief Psychiatrist, a controlling authority of an approved facility or an AMP may withhold, defer giving or quality information that is given to a patient, or to any private person about a patient.

When and how information may be withheld, deferred or qualification is set out in the section.

13.3 Prohibition on Publication

Section 133 of the Act makes it an offence for a person who publishes information for financial or other gain to publish certain information about involuntary patients and forensic patients unless the publication is authorised by the patient and, if the patient is a forensic patient, the CFP.

13.4 Disclosure of Confidential or Personal Information

Section 134 of the Act makes it an offence for a person who obtains information of a confidential or personal nature about a patient in discharging any responsibilities under the Act to disclose the information.

Exceptions to this prohibition are set out in subsection 134(2) and include if the disclosure is authorised or required by law or any court, if the patient consents to the disclosure, or if the treating medical practitioner considers it necessary for the patient’s treatment and care to disclose the information.

13.5 Record Keeping

The Act requires records of relevant matters to be kept. It also requires records of relevant matters to be provided to patients and others.

13.5.1 Records Generally

The Act requires medical practitioners and others to make records of relevant matters.

The Act also requires certain actions to be taken with respect to records that are made. This includes providing a copy of relevant records to patients and others and placing a copy of relevant records on the patient’s clinical record.

Requirements associated with record keeping under the Act are detailed in Appendix 8.

13.5.2 Monthly Reports on Voluntary Inpatients

Section 136 of the Act requires the controlling authority of an approved facility to provide the MHT and CCP with a report on the accommodation and treatment of people who have been voluntary inpatients of an approved facility for more than four months.

The MHT may review the status of any long-term voluntary inpatient and provision of the report as required by section 136 facilitates this.

13.5.3 Forensic Patient Records

Under section 114 of the Act the controlling authority of a secure mental health unit is required to keep appropriate records of matters in respect of forensic patients including admissions and discharges, police visits, the exercise of visitation, telephone and correspondence rights and any searches, detentions and arrests.

The controlling authority is also required to provide a copy of records kept to the MHT and the CFP on a weekly basis.
The MHT and/or CFP have review and oversight functions in relation to these matters and provision of the report as required by section 114 facilitates this.

### 13.6 Information for Parents

Under section 137 of the Act makes it a requirement for notices or documentation that the Act requires to be given to a patient to be given to the parent of a patient who is a child, unless the child objects to this occurring.

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<th>Question 22:</th>
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<td>Are provisions of the Act for information management and record keeping operating effectively and efficiently?</td>
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14. Mental Health Tribunal

The MHT is established by the Act and its functions and powers are set out in the legislation.

Matters relevant to the MHT are provided for in sections 167 – 199, and Schedules 3 and 4 of the Act.

Together with the Chief Psychiatrists and Official Visitors, the MHT provides an important review and oversight role.

The MHT is an independent statutory body with a role in protecting the rights, safety, inclusion and dignity of people who are involuntarily treated for mental illness.

The MHT is managed within the Department of Justice and is not connected to any hospital or other facility or organisation that provides mental health services.

More information about the MHT can be found here: www.mentalhealthtribunal.tas.gov.au/

14.1 Establishment

Under section 167 of the Act, the MHT consists of:

• at least one member who is an Australian lawyer with at least five years’ standing as an Australian legal practitioner
• at least one member who is a psychiatrist
• at least four other members.

Each of the members is appointed by the Governor.

The Governor may appoint one of the members who is an Australian lawyer as President, and one of the other members as Deputy President.

Schedule 3 of the Act applies to the MHT’s membership. Under Schedule 3:

• The President and Deputy President hold office for terms of five years and may be reappointed.
• Other MHT members hold office for terms of up to three years each and may be reappointed.

Schedule 3 also:

• provides for the circumstances in which a member vacates office or is removed as a member
• confirms the ability for the Deputy President to exercise and perform the President’s powers and functions and the circumstances in which this may occur
• provides the President with the ability to delegate the exercise and performance of any of the President’s powers and functions, other than the power to delegate, to the Deputy President, and
• provides the President of the Tribunal with power to authorise a person with special expertise to provide the MHT with expert assistance in MHT proceedings or other matters.

Ms Yvonne Chaperon was appointed to be President of the Tribunal for a term of five years in April 2014. Ms Chaperon was appointed for a second five-year term in June 2019.

Mr Richard Gruber was appointed to be the Deputy President for a term of five years in December 2018.

At the time this document was prepared, there were 39 additional appointed members.
14.1.1 Registrar and Staff

Arrangements for the appointment of a Registrar and staff of the MHT are set out in section 176 of the Act.

Section 176 enables a State Servant to be appointed as Registrar, with responsibility for this sitting with the Secretary of the Department of Justice. This includes determining whether a person to be appointed as Registrar possesses suitable qualifications and has appropriate experience, as part of the recruitment processes that apply generally whenever a person becomes a Department of Justice employee.

14.1.2 Independence

The President, Deputy President and other members appointed to the MHT may be State Service officers or employees but do not have to be. The State Service Act 2000 (Tas) does not however apply to members in their capacity as MHT members.

14.1.3 Reporting

Under section 178 of the Act, the President of the MHT is required to give the Minister for Justice a report on the MHT’s activities during the previous financial year (an Annual Report). The Minister for Justice is in turn required to cause a copy of the Annual Report to be laid before each House of Tasmanian Parliament within ten sitting days of the House, after receiving the Report.

Annual Reports that have been prepared by the President of the Tribunal since the Act’s commencement can be found here: www.mentalhealthtribunal.tas.gov.au/annual_reports

14.2 Functions and Powers

The MHT’s functions are set out in sections 168. They include:

- making, varying, renewing and discharging Treatment Orders
- authorising treatment for forensic patients
- authorising special psychiatric treatment
- determining applications for leave from secure mental health units for certain forensic patients.

The MHT also has responsibility for reviewing various matters. These matters, and the way in which the MHT is to conduct review, are set out in sections 180 – 193 of the Act and extracted at Appendix 10.

The MHT has the power to do the things that need to be done for it to perform its functions, and specific powers that are given to it by the Act or any other Acts.

The powers that the MHT has on review are set out in section 194 and Schedule 4 of the Act. In particular, the MHT may:

- combine a mandatory review with a discretionary review
- refer any matter concerning a review to the relevant Chief Psychiatrist for possible direct intervention
- issue related or incidental directions when making a determination
- require a person to appear before it to give evidence or produce documents and to answer questions
- require a patient in proceedings to be examined with respect to the patient’s physical, psychological and mental capacities by a medical practitioner
• require reports from a Chief Psychiatrist or the controlling authority of an approved facility
• visit and interview a patient by or in respect of whom an application has been made, in private.

14.2.1 Powers of the President

Under section 169, the President of the Tribunal has the power to issue guidelines on relevant matters, require reports on relevant matters, and approve forms.

The President may also:
• authorise the Registrar to review certain matters on the President’s behalf. The circumstances in which this may occur are set out in section 197 of the Act
• direct the Registrar or an MHT staff member to do a preliminary evaluation of an application and report back to the MHT accordingly. This may involve provisionally checking the merits of an application or any facts or claims made in it. Section 198 governs such evaluations, and
• issue, vary, revoke and publish practice directions in relation to the MHT’s practice and procedure under Schedule 4.

14.2.1.1 MHT Guidelines

The President of the Tribunal may issue guidelines on matters within the MHT’s jurisdiction. These are referred to in the Act as MHT Guidelines.

Failure by a person to comply with MHT Guidelines is not an offence but does constitute proper grounds for instituting professional or occupational disciplinary action.

No MHT Guidelines have been issued.

14.2.1.2 Approved Forms

The Act requires various matters to be documented in a form approved by the President of the Tribunal. To this end the President of the Tribunal has approved forms for the following matters:

• Treatment Orders
• documentation evidencing a Treatment Order’s discharge (Discharge Paper)
• authorisation of treatment for a forensic patient
• interim authorisation of treatment for a forensic patient, and any revocation or variation of this
• monthly reports on the accommodation and treatment of long-term voluntary inpatients
• applications to the MHT for reviews and other matters.

Each of the forms that has been approved by the President of the MHT, along with other forms that have been developed to facilitate the MHT’s processes, can be found here:
www.mentalhealthtribunal.tas.gov.au/forms_listing

Each of the MHT’s forms can be completed electronically.
14.2.1.3 Practice Directions

Under Schedule 4 of the Act, the MHT may issue practice directions in relation to the MHT’s practice and procedure. These are binding on the MHT, unless the Act provides otherwise.

The MHT has issued 28 practice directions to date.

Question 23:

Are provisions of the Act for the establishment, powers and functions of the Mental Health Tribunal operating effectively and efficiently?

14.3 Tribunal Proceedings

The MHT’s proceedings are regulated by section 167 and Schedule 4 of the Act.

Under section 167 of the Act, the MHT may regulate its own proceedings, and under Schedule 4 of the Act it may sit at such times and places as the President determines.

Schedule 4 of the Act also identifies the people with standing to institute or intervene in proceedings.

14.3.1 General Procedures

Under Schedule 4 of the Act, the MHT:

• is required to ensure that a party to proceedings is given notice of each hearing held in the course of those proceedings
• must proceed with as little formality as possible
• must observe the rules of natural justice
• is not bound by the rules of evidence.

14.3.2 Evidence, Representation and Privacy

Schedule 4 of the Act provides as follows:

• evidence that is given to the MHT is not admissible in civil or criminal proceedings
• a party to proceedings is entitled to attend the hearings to be held in those proceedings. However, the MHT may exclude any person from proceedings in relevant circumstances
• a party to proceedings may appear personally in the proceedings or be represented and the MHT may arrange for a person’s representation if it considers that the person cannot do so for him or herself
• a patient is entitled, when attending proceedings in any capacity, to be dressed in ordinary clothing
• MHT proceedings are not open to the public unless the MHT determines otherwise.

14.3.3 Publication of Proceedings, Announcement of Decisions and Statements of Reasons

Under Schedule 4 of the Act the MHT is required to make and keep a record of its proceedings.

The MHT may also publish a record of any of its proceedings (suppressing information as relevant) and is required to provide any record that is published to every party in proceedings.

The MHT may announce its determination at the end of proceedings. The way this is to occur are set out in Schedule 4.
Any party to proceedings may apply to the MHT within 30 days of proceedings being finally determined for a written statement of reasons for making a determination. The MHT is to comply with such a request within 21 days of receiving it, and any statement of reasons that is produced is to be provided to every party to the proceedings.

14.3.4 Divisions and Acting by Majority

Under section 170 of the Act, the MHT may sit in divisions.

A division consists of one member, or three or more members, who have been chosen by the President of the MHT to constitute the division. This may be for a specific case, or for a class of cases.

When choosing members to be part of a division, the President of the Tribunal is required to have regard to the nature of the matters that the division will be required to consider and the need for the members to have appropriate knowledge and experience. The President must also ensure that each division of three or more members has at least one member who is an Australian lawyer, and at least one member who is a psychiatrist.

The MHT is required to conduct certain proceedings before a division of three members. This includes:

- hearings to determine applications for Treatment Orders under section 39 of the Act
- authorisation of treatment for forensic patients under section 88 of the Act
- authorisation of special psychiatric treatment under section 126 of the Act
- reviews of Treatment Orders (other than reviewed in respect of which section 47A of the Act applies) under section 181 of the Act
- reviews of the authorisation of treatment for forensic patients under section 192A of the Act, and
- proceedings to consider correcting an order, determination, direction or other document under section 224A of the Act.

Section 171 of the Act confirms the MHT’s ability, when constituted of three or more members, to act by majority. Schedule 4 provides more information about how a majority is determined.

14.3.5 Determinations

14.3.5.1 Evidence of Tribunal Determinations

Section 199 of the Act requires MHT determinations and directions to be signed by the Registrar, or an MHT member who was involved in making the determination or direction and confirms that a determination or direction that is so signed is evidence of the determination or direction.

14.3.5.2 Interim Determinations on Adjournment

Under section 172 of the Act, the MHT may adjourn proceedings and make any interim orders or determinations it considers appropriate in the circumstances. This includes making or renewing Treatment Orders on an interim basis in proceedings that are adjourned.

14.3.6 Questions of Law and Appeals

Under section 173, the President of the Tribunal may seek a special determination from the Supreme Court of Tasmania on questions of law that arise in hearings or in the determination of any proceedings.

The circumstances in which an appeal may be made in respect of an MHT determination, and the procedure for this are set out in sections 173 and 174 of the Act respectively.
14.3.7 Refusal of Reviews, On-Paper Reviews and Preliminary Evaluation

The circumstances in which the MHT may refuse to review a matter on application are set out in section 196 of the Act. These include if the MHT has reviewed the matter within the past three months.

Under section 197 of the Act, the President of the Tribunal may authorise the Registrar to review certain matters and a review done by the Registrar in these circumstances is as valid as if it had been done by the MHT.

The circumstances in which the Registrar may conduct an on-paper review are narrow. In particular, the Registrar may only conduct reviews on the papers if authorised to do so by the President of the Tribunal; and the President may only authorise the Registrar to conduct a review on the papers if satisfied that no hearing is required, and that it is within the Registrar’s competence to do such a review. The ability for the Registrar to conduct a review on the papers additionally does not extend to a 60-day or 180-day review of a Treatment Order, or a 60-day or 180-day review of the authorisation of treatment for a forensic patient.

14.3.8 Contempt

The circumstances in which a person will be in contempt of the MHT include:

- if the person insults a member of the MHT, the Registrar, an MHT staff member or other person assisting the Tribunal
- if the person deliberately interrupts the MHT or creates a disturbance, or
- if the person obstructs or assaults a person attending an MHT hearing.

14.4 Other Developments

The Department of Justice released a Discussion Paper proposing establishment of a Single Tribunal for Tasmania in September 2015. While the Department of Justice is understood to continue to be moving towards achievement of a Single Tribunal the timelines for this, and whether the MHT would be amalgamated as part of the Single Tribunal’s establishment, are unclear.

Question 24:

Are provisions of the Act for the Mental Health Tribunal’s proceedings and determinations operating effectively and efficiently?
15. Official Visitors

The Act provides for the appointment, powers and functions of a Principal Official Visitor, and Official Visitors.

Sections 154 – 166 of the Act regulates the appointment, functions and powers of the Principal Official Visitor and Official Visitors and provide for associated matters.

Together with the Chief Psychiatrists and MHT, Official Visitors provide an important review and oversight role.

The first Mental Health Official Visitor scheme was established in Tasmania in 1885, when Official Visitors were appointed to review facilities at New Norfolk and the Cascades. The appointment of independent hospital visitors was a recommendation of a national inquiry into the human rights of people with mental illness commissioned by the Human Rights Commission in 1993, and the inclusion in legislation of provisions for the appointment of independent community visitors to mental health care agencies was supported in the Model Mental Health Legislation Report to the Australian Ministers Advisory Council National Working Group on Mental Health Policy in 1995.

The Mental Health Act 1996 provided for Official Visitors and the first Official Visitors were appointed in 2000, to coincide with that Act’s commencement. The role and function of Official Visitors under the Act is broadly reflective of the role and function that Official Visitors had under the Mental Health Act 1996.


15.1 The Principal Official Visitor

The Principal Official Visitor is appointed by the Governor on the recommendation of the Minister for Justice.

Under Schedule 5 of the Act, the Principal Official Visitor holds office for a term of up to five years and may be reappointed to the role. Schedule 5 also provides for the circumstances in which a Principal Official Visitor may vacate office or be removed from the relevant office.

Mr Richard Connock was appointed to be Principal Official Visitor for a second term of five years in July 2019. Mr Connock is also the Ombudsman and Health Complaints Commissioner for Tasmania.

15.1.1 Functions and Powers

The functions of the Principal Official Visitor are set out in section 156 of the Act and include:

- arranging for Official Visitors to visit approved hospitals, approved assessment centres and secure mental health units
- arranging for Official Visitors to visit premises from which voluntary inpatients, involuntary patients and forensic patients are provided with services under the Act
- receiving complaints from, or about, voluntary inpatients, involuntary patients and forensic patients
- referring suspected contraventions of the Act, or other matter that may need investigation, to the Health Complaints Commissioner or to the Ombudsman
- reporting on the extent to which the Act’s objects and the mental health service delivery principles are being met
• raising matters of concern that come to the Principal Official Visitor’s attention with the Minister for Health or the relevant Chief Psychiatrist, and

• determining how Official Visitors are to perform their functions.

The Principal Official Visitor has the power to do what is necessary or convenient to perform his or her functions.

The Principal Official also has the power to delegate any of his or her functions, other than the power of delegation itself, to an Official Visitor. The power to do so is set out in section 158 of the Act.

15.1.2 Independence

The Act requires the Principal Official Visitor to act independently, impartially and in the public interest, and to have regard to the Act’s objects and the mental health service delivery principles, when performing functions, exercising powers and forming related opinions.

There are limitations on who can be appointed as Principal Official Visitor, and a person cannot be appointed to the office if he or she holds certain appointments or interests. The circumstances in which a person cannot be appointed are set out in subsection 155(3) of the Act.

The person appointed to the office of Principal Official Visitor may be a State Service officer or employee but does not have to be.

The State Service Act does not apply to the performance of functions by the Principal Official Visitor.

The person appointed as Principal Official Visitor is employed by the Department of Justice and is functionally located in the Office of the Ombudsman and Health Complaints Commissioner. Administrative support for the performance of Official Visitor functions is provided by that Office.

15.1.3 Reporting

The Principal Official Visitor has the following reporting obligations:

• If the Principal Official Visitor knows or reasonably suspects that the Act has been contravened in any material way, he or she is to report the matter to the Health Complaints Commissioner or Ombudsman, whichever body seems appropriate in the circumstances.

• The Principal Official Visitor is required to give the Minister for Health, and relevant Chief Psychiatrist, a written report on a quarterly basis. A copy is also to be provided to the controlling authority of the facility that the person is in or to the person in charge of the premises from which relevant services are provided, as relevant.

• The Principal Official Visitor is also required to give the Minister for Health, and relevant Chief Psychiatrist, a report on matters of concern if requested by the Minister. A copy is also to be provided to the controlling authority of the facility that the person is in or to the person in charge of the premises from which relevant services are provided, as relevant.

15.1.4 Identification

The Secretary is required under section 164 of the Act to issue the Principal Official Visitor with an identity card. The Principal Official Visitor must display his or her identity card when performing functions under the Act and must allow the card to be inspected on demand.
15.2 Official Visitors

Official Visitors are appointed by the Principal Official Visitor. Under Schedule 5 of the Act, an Official Visitor holds office for a term of up to three years and may be reappointed to the role.

There are currently 10 people appointed as Official Visitors for the State.

The Principal Official Visitor is required under section 164 of the Act to issue Official Visitors with identity cards. An Official Visitor must display his or her identity card when performing functions under the Act and must allow the card to be inspected on demand.

15.2.1 Functions and Powers

Official Visitor functions are set out in section 157 of the Act and include:

- visiting approved hospitals, approved assessment centres and secure mental health units in accordance with arrangements made by the Principal Official Visitor for this purpose
- visiting premises from which voluntary inpatients, involuntary patients and forensic patients are being provided with services under the Act, again in accordance with arrangements made by the Principal Official Visitor for this purpose
- receiving complaints from, or about, voluntary inpatients, involuntary patients and forensic patients and referring these to the Principal Official Visitor
- reporting suspected contraventions of the Act to the Principal Official Visitor
- checking that patients are being informed of, and given, their rights, and
- monitoring the adequacy and quality of approved hospital, approved assessment centres and secure mental health units with a focus on the recreational, occupational, training and rehabilitation facilities that are available.

Official Visitors have the power to do what is necessary or convenient to perform his or her functions.

15.2.2 Independence

As with the Principal Official Visitor, the Act requires Official Visitors to act independently, impartially and in the public interest, and to have regard to the Act’s objects and the mental health service delivery principles, when performing functions, exercising powers and forming related opinions.

The person appointed as an Official Visitor may be a State Service officer or employee but does not have to be.

The State Service Act does not apply to the performance of functions by an Official Visitor.

15.3 Visits

Visits are regulated under section 160 of the Act.

Under that section, the Principal Official Visitor is required to arrange for an Official Visitor to visit each approved hospital, approved assessment centre and secure mental health unit on at least a monthly basis. The purpose of such visits is to monitor the adequacy and quality of approved facilities, with particular regard to the recreational, occupational, training and rehabilitation facilities available to patients.

The Principal Official Visitor is also required to arrange for an Official Visitor to visit premises in, or from which, a voluntary inpatient, involuntary patient or forensic patient is being provided with services under the Act but only if asked to do so by:
• the patient
• a representative or support person of the patient
• a person who the Principal Official Visitor believes has a genuine interest in the patient’s welfare, or
• the Minister for Health.

The Principal Official Visitor does not have to conduct a visit to premises if the premises have been visited in the past month or if the Principal Official Visitor considers that the request is frivolous or vexatious.

Visits may be made with or without notice.

15.4 Complaints

Any voluntary inpatient, involuntary patient or forensic patient is entitled to make a complaint to an Official Visitor.

A support person or representative of the patient, or a person who the Principal Official Visitor believes has a genuine interest in the patient’s welfare may also make a complaint, concerning a voluntary inpatient, involuntary patient or forensic patient, to an Official Visitor.

15.4.1 Obligation to Assist

The Act requires any person who is discharging responsibilities under the Act to give patients who wish to make a complaint help to do so.

Specifically, any person who is discharging responsibilities under the Act and who becomes aware of a patient’s wish to see or complain to an official is required to:

• inform an Official Visitor of that wish within 24 hours, and
• to the extent of the person’s legal and physical capacity to do so, to:
  o grant an Official Visitor access to relevant parts of premises (being parts of the premises in which the patient is being accommodated, or assessed or treated)
  o facilitate private and direct communication between the patient and Official Visitors (to the extent that the patient wants this to occur)
  o grant Official Visitors access to records relating to the patient’s assessment, treatment and care (unless the patient has asked that this not occur)
  o grant Official Visitors access to other relevant records or registers that the Act requires are kept
  o answer questions, to be best of the person’s knowledge and in a full and frank manner, about the patient’s assessment, treatment or care (unless the patient has asked that this not occur), and
  o give Official Visitors other reasonable assistance.

Question 25:

Are provisions of the Act for the appointment, powers and functions and other matters associated with Official Visitors operating effectively and efficiently?
16. Chief Civil Psychiatrist and Chief Forensic Psychiatrist

The Act provides for the offices of Chief Civil Psychiatrist and Chief Forensic Psychiatrist.

The Governor may appoint a person to be Chief Civil Psychiatrist, and a person to be Chief Forensic Psychiatrist, under sections 143 and 144 of the Act respectively. In each case the person appointed must be a psychiatrist with at least five years’ experience in practicing psychiatry.

The person appointed may be a State Service officer or employee but does not have to be, and the same person may be appointed to each office.

The Chief Psychiatrists hold office for terms of up to five years and may be reappointed. Dr Aaron Groves was appointed to be Chief Civil Psychiatrist and Chief Forensic Psychiatrist in November 2017. Each appointment is for a five-year term.

Dr Groves is a State Service officer and holds the position of Chief Psychiatrist. The position is functionally located within the Mental Health, Alcohol and Drug Directorate, which is a part of the Department of Health.

Together with the MHT and Official Visitors, the Chief Psychiatrists provide an important review and oversight role.

The statutory position of CFP was introduced to the Mental Health Act 1996 in 2006 to provide a review role in relation to forensic mental health patients. The role was widely considered to provide an important review role in relation to forensic mental health patients, and to be of value in providing an oversight and quality assurance role.

The Mental Health Act 1996 did not provide for a similar position with respect to involuntary patients and the office of Chief Civil Psychiatrist was included in the Act to address this perceived deficiency.

The legislation in place in other States and Territories provides for the concept of Chief Psychiatrists and is supported by the Model Mental Health Legislation, according to which the Chief Psychiatrist would be “responsible for the medical care and welfare of persons receiving treatment and care at a mental health facility or from a health care agency”. The establishment of an independent statutory authority to provide guidance and clarity to clinical staff in relation to the Act and to oversee clinical practice in this respect was also considered to be consistent with the then recent establishment of independent and separate Tasmanian Health Organisations.

Matters relevant to the Chief Psychiatrists are provided for in sections 143 – 153 of the Act.

16.1 Responsibilities

The CCP has a general overall responsibility, under and to the Minister for Mental Health and Wellbeing, for ensuring that the objects of the Act are met in respect of voluntary inpatients and involuntary patients, and in respect of the running of approved hospitals and approved assessment centres.

The CFP has, in turn, a general overall responsibility, under and to the Minister for Mental Health and Wellbeing, for ensuring that the objects of the Act are met in respect of forensic patients, involuntary patients who have been admitted to a secure mental health unit under section 63 of the Act, people who are subject to supervision orders and in respect of the running of secure mental health units.
16.1.1 Independence

In acting or forming any opinion in clinical matters a Chief Psychiatrist is not subject to the direction of the Minister, the other Chief Psychiatrist or any other person. This applies notwithstanding the State Service Act which would otherwise see the Chief Psychiatrists subject to Employment Directions and other directions in respect of those matters.

16.1.2 Reporting

Each of the Chief Psychiatrists is required to provide the Minister for Mental Health and Wellbeing with a report on the Chief Psychiatrists’ activities during the previous financial year (an Annual Report). The Minister for Mental Health and Wellbeing is in turn required to cause a copy of the Report to be laid before each House of Tasmanian Parliament within 10 sitting days of the House, after having received the Report.

The Minister may direct the Chief Psychiatrists to prepare the report in a particular style or format, or to include particular information in the report.

Annual Reports that have been prepared by the Chief Psychiatrists since the Act’s commencement can be found on the Parliament of Tasmania website here: www.parliament.tas.gov.au

16.2 Powers and Functions

The Chief Psychiatrists’ functions are detailed in the Act. They include:

- approving forms
- issuing Standing Orders and Clinical Guidelines
- authorising seclusion and physical restraint for child patients
- authorising chemical or mechanical restraint for child and adult patients, and
- intervening directly on the assessment, treatment and care of certain patients.

The CCP has additional functions including directing an involuntary patient’s transfer from one approved hospital to another and initiating an involuntary patient’s admission to a secure mental health unit.

The CFP also has additional functions including authorising an involuntary patient’s admission to a secure mental health unit, directing a forensic patient’s transfer to hospital, granting leave of absence from a secure mental health unit for forensic patients who are not subject to restriction orders, and functions relating to the provision of reports to the Magistrates and Supreme Courts under the Criminal Justice (Mental Impairment) Act, the Sentencing Act and other legislation.

Each Chief Psychiatrist has the power to do anything necessary or convenient to be done to perform his or her functions.

16.2.1 Approved Forms

The Act requires various matters to be documented using Chief Civil Psychiatrist or Chief Forensic Psychiatrist Approved Forms. These are forms that have been approved by the Chief Civil Psychiatrist or Chief Forensic Psychiatrist, as relevant.

Each of the forms that has been approved by the Chief Psychiatrists can be found here: www.dhhs.tas.gov.au/mentalhealth/mental_health_act/mental_health_act_2013_new_mental_health_act/forms

A full listing of the forms that have been approved is also provided at Appendix 9.
Of the forms approved by the Chief Psychiatrists, only Chief Civil Psychiatrist Approved Form 7 can be completed electronically.

16.2.2 Standing Orders

Under section 152 of the Act, each of the Chief Psychiatrists may issue directions to controlling authorities, medical practitioners, nurses and other people about the exercise of their responsibilities in respect of any procedure under provisions of the Act within the Chief Psychiatrists’ jurisdiction and provisions of other Acts in respect of which the relevant Chief Psychiatrist has responsibilities. Directions of this kind can apply to clinical or non-clinical procedures and referred to throughout the Act as Standing Orders.

Standing Orders are binding on people exercising relevant responsibilities and while failure by a person to comply with a Standing Order is not an offence it may constitute proper grounds for instituting professional or occupational disciplinary action against the person.

The CCP has issued Standing Orders in respect of the following matters:

- Urgent Circumstances Treatment (Involuntary Patients) (CCP Standing Order 8)
- Seclusion (Involuntary Patients) (CCP Standing Order 9)
- Chemical Restraint (Involuntary Patients) (CCP Standing Order 10)

The CFP has issued Standing Orders in respect of the following matters:

- Urgent Circumstances Treatment (Forensic Patients) (CFP Standing Order 8)
- Seclusion (Forensic Patients) (CFP Standing Order 9)
- Chemical Restraint (Forensic Patients) (CFP Standing Order 10)
- Mechanical Restraint and Physical Restraint (Forensic Patients) (CFP Standing Order 10A)
- Visitor Identification (CFP Standing Order 15)
- Entry Screen and Search (CFP Standing Order 16)
- Items that may not be brought into a secure mental health unit (Unauthorised Items (CFP Standing Order 17)
- The use of force (CFP Standing Order 21).

The CCP and CFP have also issued a joint Standing Order in respect of the admission of involuntary patients to a secure mental health unit (CCP and CFP Standing Order 19).

The Act imposes certain requirements with respect to Standing Orders including that they are to be written in plain language and that they are to be published. Section 153 of the Act provides more detail on these requirements.

Standing Orders that have been issued by the CCP and CFP can be found here: www.dhhs.tas.gov.au/mentalhealth/mental_health_act/mental_health_act_2013_new_mental_health_act/clinical_guidelines_and_standing_orders

16.2.3 Clinical Guidelines

Under section 151 of the Act, the Chief Psychiatrists may issue guidelines to help controlling authorities, medical practitioners, nurses and other people in the exercise of their responsibilities in respect of any treatment, clinical procedure or other clinical matter under provisions of the Act within the Chief
Psychiatrists’ jurisdiction and provisions of other Acts in respect of which the relevant Chief Psychiatrist has responsibilities. Guidelines of this kind are referred to throughout the Act as Clinical Guidelines.

Clinical Guidelines are not binding but people exercising relevant responsibilities must have regard to them. Failure by a person to comply with a Clinical Guideline is not an offence it may constitute proper grounds for instituting professional or occupational disciplinary action against the person, particularly if the failure leads to unfavourable patient outcomes that might otherwise have been avoided, or if there is a history of disregarding Guidelines on the part of the person exercising the relevant responsibility.

The CCP has issued Clinical Guidelines in respect of the following matters:
- The meaning of mental illness (CCP Clinical Guideline 1)
- The off-label use of medications (CCP Clinical Guideline 7)
- Urgent Circumstances Treatment (Involuntary Patients) (CCP Clinical Guideline 8)
- Seclusion (Involuntary Patients) (CCP Clinical Guideline 9)
- Chemical Restraint (Involuntary Patients) (CCP Clinical Guideline 10)

The CFP has issued Clinical Guidelines in respect of the following matters:
- Urgent Circumstances Treatment (Forensic Patients) (CFP Clinical Guideline 8)
- Seclusion (Forensic Patients) (CFP Clinical Guideline 9)
- Chemical Restraint (Forensic Patients) (CFP Clinical Guideline 10)
- Mechanical Restraint and Physical Restraint (Forensic Patients) (CFP Clinical Guideline 10A).

The CCP and CFP have also issued joint Clinical Guidelines in respect of decision-making capacity (CCP and CFP Clinical Guideline 2) and Representatives and Support People (CCP and CFP Clinical Guideline 3).

As with Standing Orders, the Act imposes certain requirements with respect to Clinical Guidelines. Section 153 of the Act provides more detail on these requirements.

Clinical Guidelines that have been issued by the CCP and CFP can be found here: www.dhhs.tas.gov.au/mentalhealth/mental_health_act/mental_health_act_2013_new_mental_health_act/clinical_guidelines_and_standing_orders

16.2.4 Power of Direct Intervention

Each of the Chief Psychiatrists has the power to intervene directly with regard to the assessment, treatment and care of certain patients.

The Chief Psychiatrists’ powers of direct intervention are limited, as follows:

- The power of direct intervention may only be exercised with respect to voluntary inpatients, involuntary patients or forensic patients.

- The power of direct intervention may be exercised on the Chief Psychiatrist’s own motion, or on request of the patient or any other person who, in the Chief Psychiatrist’s opinion, has a genuine interest in the patient’s health, safety or welfare.

- The power of direct intervention may only be exercised if the Chief Psychiatrist has made inquiries into the matter and is satisfied from those inquiries that intervention is essential to the patient’s health, safety or welfare.
The power of direct intervention may only be exercised in respect of the following matters:
- the use of seclusion, restraint or force
- the granting, refusal and control of leaves of absence
- the giving or withholding of patient information
- the granting, denial and control of visiting, correspondence and telephone rights
- assessment and treatment generally, and
- matters prescribed by the regulations.

The Chief Psychiatrists can exercise the power of direct intervention by giving any person responsible for the patient’s treatment and care a notice to discontinue, alter, observe or carry out a practice, procedure or treatment in respect of the patient. The Chief Psychiatrists can also issue consequential directions for the patient’s future assessment, treatment or care or direct that relevant matters be referred to the MHT.

The Chief Psychiatrists cannot however issue directions which are repugnant to any provision of the Act or of any other Act, or to an order, determination or direction of the MHT or any Court. This effectively prevents a Chief Psychiatrist from using the power of direct intervention to achieve an outcome that would be contrary to the provisions, including the objects and principles, of the Act.

The MHT has jurisdiction to review decisions made by the Chief Psychiatrists under section 146 of the Act.

### 16.2.5 Delegation

Each of the Chief Psychiatrists has the power to delegate his or her powers or functions under the Act, or any other Act, other than:

- the power of delegation
- the power to issue, vary or revoke Standing Orders and Clinical Guidelines
- powers related to special psychiatric treatment.

Some powers may only be delegated to a medical practitioner. This includes the power to:

- authorise seclusion or restraint or the extension of seclusion or restraint
- direct patient transfers
- make decisions about admitting involuntary patients to, or detaining involuntary patients at, a secure mental health unit
- make decisions about the transfer of prisoners or youth detainees with mental illness or disability to a secure mental health unit under the Corrections Act or Youth Justice Act
- make decisions to return forensic patients who are also prisoners or youth detainees to prison or youth detention
- make decisions about leave of absence for forensic patients.

The Chief Psychiatrists can delegate their functions or powers to:

- a person by name, or
- the holder of a State Service office or position, by reference to the title of the office or position concerned.
This is by virtue of section 23AA of the Acts Interpretation Act 1931 (Tas), which applies to the Chief Psychiatrists' power to delegate.

In most cases, delegations are issued to the holder of identified State Service offices or positions rather than to people by name. This is however occasionally necessary to provide for locum medical practitioners, who generally do not hold State Service offices or positions. Delegations that are issued to people by name are generally time limited and subject to conditions.

**Question 26:**

Are provisions of the Act for the appointment, powers and functions and other matters associated with the Chief Psychiatrists operating effectively and efficiently?
17. Interstate Arrangements

Orders made under the Act apply only in Tasmania and do not automatically have effect in other States and Territories.

Historically, jurisdictions have sought to address this issue by including provisions for bilateral (or Ministerial) agreements in mental health legislation. Agreements of this kind have effect to “activate” legislative provisions that allow the transfer and return of people subject to mental health orders from one jurisdiction to another.

Tasmania adopted this approach in the Mental Health Act 1996 and provisions from that Act were carried over to the Act when the Act was developed with minimal changes. They appear in Chapter 4 of the Act (sections 200 – 210).

17.1 Interstate Transfer Agreements

The Minister for Mental Health and Wellbeing can enter into an Interstate Transfer Agreement with the Minister’s counterpart in another jurisdiction, providing for the interstate transfer on humanitarian grounds of involuntary patients, forensic patients, or people who are subject to supervision orders under Part 2 of Chapter 4 of the Act.

Tasmania does not have any Interstate Transfer Agreements in place with other jurisdictions.

17.2 Interstate Control Agreements

The Minister for Mental Health and Wellbeing can enter into an Interstate Control Agreement with the Minister’s counterpart in another jurisdiction, providing for the apprehension, detention and return of involuntary patients or forensic patients who have absconded from Tasmania and who are found “at large” in the other jurisdiction, and for the apprehension, detention and return of people who have absconded from the other jurisdiction, and who are found “at large” in Tasmania under Part 3 of Chapter 4 of the Act.

Tasmania does not have any Interstate Control Agreements in place with other jurisdictions.

17.3 Tasmanian Context

Despite attempts over the years to develop interstate agreements with other jurisdictions, Tasmania has not been successful in finalising negotiations for this purpose and as such, provisions for interstate agreements are not operational.

There are many reasons for this. The legislation in place in jurisdictions uses distinct frameworks and terminology and imposes unique requirements for transfer, all of which makes development and implementation of agreements complex and time consuming. As a small jurisdiction Tasmania has also found it difficult to prioritise development of agreements over other work.

17.4 Other Developments

Tasmania is not the only jurisdiction to have experienced difficulties in developing and maintaining interstate agreements.

This is because the current approach (of including legislative provisions for the transfer and return of people subject to mental health orders from one jurisdiction to another that are operationalised by interstate agreements) creates a complex set of arrangements between jurisdictions. This complexity is exacerbated when legislation changes, or an agreement expires. In the past decade many jurisdictions have made significant changes to their legislation and this has necessitated re-negotiation of existing agreements for those jurisdictions with agreements in place and deferred the progress of new agreements for others.
The potential for such changes requires jurisdictions to be proactive in ensuring the ongoing validity of interstate agreements.

In recognition of these challenges, in 2018 the then Tasmanian Minister for Health Michael Ferguson MP raised issues with the transfer and return of people subject to mental health orders between jurisdictions and options for dealing with this with his State and Territory counterparts.

Action 26 of the Fifth Plan requires Governments to improve consistency across jurisdictions in mental health legislation with a view to ensuring seamless and safe care for consumers, particularly consumers who move between states and territories. Queensland and Tasmania are project leads for Action 26 of the Fifth Plan and have jointly developed a paper exploring options for how best to deal with the transfer and return of people subject to mental health orders from one jurisdiction to another. The paper is expected to be considered by Ministers later in 2019.

One outcome of this process may be an agreement from jurisdictions including Tasmania to commit to pursuing a national legislative scheme to give effect to mechanisms which enable mental health orders made in one jurisdiction to be recognised and enforced in other participating jurisdictions. If adopted and supported in Tasmania, adoption of this approach would see the provisions of the Act that provide for interstate agreements replaced with new, model provisions and a different mode of operation.

This type of approach would reflect the approach taken to address cross-border issues associated with domestic violence orders through the National Domestic Violence Order Scheme which allows domestic violence orders to be automatically recognised and enforceable in any state or territory of Australia.

It would also reflect the approach taken in South Australia’s mental health legislation through the inclusion of provisions for the recognition of interstate mental health orders in that jurisdiction in certain circumstances.

**Question 27:**

Provisions of the Act for interstate agreements (sections 200 – 210) are not operational and it is not proposed to make any changes to the provisions until such time as Ministers have considered the issue and whether to commit to pursuing a national legislative scheme. Feedback on any aspect of these sections is nevertheless welcomed.
18. Other Matters

18.1 Rights and Responsibilities of Carers and Family Members

The Act seeks to maximise and promote consumer involvement in decision-making while facilitating the involvement of carers and family members to the extent that this is consistent with the consumer’s wishes.

The Act requires people exercising responsibilities under the Act to have regard to a range of principles, including:

- to recognise the difficulty, importance and value of the role played by families and support persons of persons with mental illness
- to involve persons receiving services and where appropriate their families and support persons in decision making
- to recognise families, and support persons, of persons with mental illness as partners, with mental health service providers, in the provision of their treatment and care to the extent that this is appropriate and consistent with the person’s own wishes, and
- to respect the wishes of persons receiving services, and the wishes of their families and support persons, to the maximum extent consistent with the health and safety of those persons and the safety of others.

The Act also facilitates the specific involvement of carers and family members of people with mental illness in the person’s care and treatment in the following ways:

- A guardian, parent or support person of a person with a mental illness may apply to a medical practitioner for an Assessment Order for that person in certain circumstances.
- A carer, family member or other support person of a person with a mental illness may be consulted by a medical practitioner in the preparation or revision of the person’s treatment plan in certain circumstances.
- A carer, family member or other support person may be notified of a person’s admission to, transfer between or discharge from an approved hospital or secure mental health unit, and of certain matters related to the person’s leave of absence from such a facility.
- A carer, family member or other support person may be provided with personal or confidential information about a person with a mental illness if the person’s treating medical practitioner considers this to be necessary for the person’s treatment or care.
- A carer, family member or other support person of a person with a mental illness may make a complaint to the Principal Official Visitor.
- A representative or support person of a person with a mental illness may ask for the Principal Official Visitor to visit premises from which the person is being provided with services under the legislation.
- A representative of a person with a mental illness, or any other person that the MHT considers has a proper interest in the matter, may institute or intervene in MHT proceedings.
- A carer, family member or other support person of a person with a mental illness who institutes or intervenes in MHT proceedings has the right to attend the hearings held in those proceedings, and to appear personally or be represented by an Australian legal practitioner, advocate or other person in relation to those proceedings.
As has already been noted, parents of children with mental illness also have:

- the ability to provide, withdraw or refuse consent to the assessment or treatment of a child patient who lacks decision making capacity in this regard, and
- the right to be given a copy of documentation that is given to a child patient unless the child objects to this occurring.


**Question 28:**

Is the Act operating as intended to maximise and promote consumer involvement in decision-making while facilitating the involvement of carers and family members to the extent that this is consistent with the consumer’s wishes? If not, why do you think this is?

**18.2 Offences**

The Act provides for several offences. Advice received to date suggests that none of the offences has been prosecuted.

**18.2.1 Unlawful Treatment**

Section 213 makes it an offence for a person to give a patient a treatment without informed consent or, in the absence of informed consent, authorisation under the Act or any other law.

**18.2.2 Neglect or Ill-Treatment**

Section 214 makes it an offence for:

- a person to intentionally ill-treat a person knowing that the person has a mental illness and is, in consequence of the illness, unable to take proper care of himself or herself, and
- a person in a position of responsibility to intentionally ill-treat a person knowing that the person has a mental illness and is, in consequence of the illness, unable to take proper care of himself or herself.

**18.2.3 Obstruction**

Section 215 makes it an offence for a person to obstruct or hinder an AMP, approved nurse, authorised person, Chief Psychiatrist, a member of the MHT, an MHO, the Principal Official Visitor or an Official Visitor, the Registrar or an MHT staff member, the MHT or the controlling authority of an approved facility in discharging any responsibilities under the Act.

**18.2.4 Contravention of Tribunal Determinations**

Section 216 makes it an offence for a person to contravene a determination or direction of the MHT.

**18.2.5 False or Misleading Statements**

Section 217 makes it an offence for a person to make a statement knowing it to be false or misleading, or to omit any matter from a statement knowing that without the matter the statement is false or misleading, in giving any information under the Act.
18.3 Immunities

Section 218 of the Act provides AMPs, approved nurses, authorised persons, Chief Psychiatrists, members of the MHT, MHOs, the Principal Official Visitor or an Official Visitor, the Registrar or an MHT staff member with the immunities set out in the section.

| Question 29: |
| Are provisions of the Act relating to offences and immunities operating effectively and efficiently? |

18.4 Miscellaneous

18.4.1 Remote Medical Procedures

Section 211 confirms that assessments, examinations, diagnosis and treatment and other medical procedures may be carried out in person or by video conferencing or use of other technical means allowed by the operating protocols of the facility from or in which the procedure is carried out, Clinical Guidelines or Standing Orders.

18.4.2 Powers of Sedation

An ambulance officer or medical practitioner who is approved as an MHO under the Act may sedate a patient who is being transported by ambulance in the circumstances set out in section 212 of the Act.

18.4.3 Conflicts of Interest

Section 222 regulates conflicts of interest and identifies when a person has a clear conflict of interest and prevents a person with a clear conflict of interests from discharging responsibilities in respect of patients under the Act.

18.4.4 Correction of Orders

The circumstances in which an error in a form that does not affect the validity of an Order, determination, direction or other document under the Act may be corrected are set out in section 224 of the Act.

The circumstances in which an error in an Order, determination, direction or other document made by the MHT under the Act that affects the validity of the Order, determination, direction or other document may be corrected are set out in section 224A of the Act.

| Question 30: |
| Are provisions of the Act relating to remote medical procedures, powers of sedation, conflicts of interest and the correction of orders operating effectively and efficiently? |

| Question 31: |
| Are there any other aspects of the Act’s operation that you would like to comment on? |
## Appendix 1 Representative Bodies or Groups

<table>
<thead>
<tr>
<th>Body or Group</th>
<th>Contact Details</th>
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<tbody>
<tr>
<td>Flourish Mental Health Action In Our Hands Inc</td>
<td>Write Po Box 4836 Bathurst Street Post Office HOBART TAS 7000</td>
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<tr>
<td></td>
<td>Call 03 6223 1952</td>
</tr>
<tr>
<td></td>
<td>Email <a href="mailto:ivanz@flourishtas.org.au">ivanz@flourishtas.org.au</a></td>
</tr>
<tr>
<td>Advocacy Tasmania</td>
<td>Call 1800 005 131</td>
</tr>
<tr>
<td></td>
<td>Email <a href="mailto:advocacy@advocacytasmania.org.au">advocacy@advocacytasmania.org.au</a></td>
</tr>
<tr>
<td>Mental Health Families and Friends Tasmania Inc. (formerly known as Mental Health Carers Tasmania)</td>
<td>Write 2 Terry Street GLENORCHY TAS 7010</td>
</tr>
<tr>
<td></td>
<td>Call 03 6228 7448</td>
</tr>
<tr>
<td></td>
<td>Email <a href="mailto:admin@mentalhealthcarerstas.org.au">admin@mentalhealthcarerstas.org.au</a></td>
</tr>
<tr>
<td>Carers Tasmania</td>
<td>Write 64 Burnett Street NORTH HOBART TAS 7000</td>
</tr>
<tr>
<td></td>
<td>Call 03 6144 3700</td>
</tr>
<tr>
<td></td>
<td>Email <a href="mailto:peak@carerstasmania.org">peak@carerstasmania.org</a></td>
</tr>
<tr>
<td>Royal Australian and New Zealand College of Psychiatrists Tasmanian Branch</td>
<td>Write GPO Box 1236 HOBART TAS 7001</td>
</tr>
<tr>
<td></td>
<td>Call 03 6270 2260</td>
</tr>
<tr>
<td></td>
<td>Email <a href="mailto:christine.walker@ranzcp.org">christine.walker@ranzcp.org</a></td>
</tr>
<tr>
<td>Australian College of Mental Health Nurses Tasmanian Branch</td>
<td>Write GPO Box 125 HOBART TAS 7001</td>
</tr>
<tr>
<td></td>
<td>Call 0418 697 574</td>
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<tr>
<td></td>
<td>Email <a href="mailto:cecily.pollard@ths.tas.gov.au">cecily.pollard@ths.tas.gov.au</a></td>
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</tbody>
</table>
Appendix 2 Glossary of Terms

In this Consultation Paper, the following terms are used:

- “the Act” means the Mental Health Act 2013 (Tas)
- “AMP” means an Approved Medical Practitioner
- “Approved Medical Practitioner” means a person who has been approved under section 138 of the Act
- “assessment” is the clinical process involved in diagnosing the condition of a person’s mental health and, where necessary, identifying the most appropriate treatment
- “Assessment Order” means an Assessment Order made under Division 1 of Part 3 of Chapter 2 of the Act
- “Australian Lawyer” means a person who is admitted to the legal profession under the Legal Profession Act 2007 (Tas) or a corresponding law
- “CCP” means Chief Civil Psychiatrist
- “CFP” means Chief Forensic Psychiatrist
- “Chief Civil Psychiatrist” means the person for the time being holding or acting in the office referred to in section 143 of the Act
- “Chief Forensic Psychiatrist” means the person for the time being holding or acting in the office referred to in section 144 of the Act
- “child” means a person who is under 18 years of age
- “controlling authority” means the Secretary, for approved facilities run by or on behalf of the State. For any other approved facility, the controlling authority is the person who is in overall charge of the day-to-day clinical management of the facility at the relevant time
- “decision-making capacity” means a person’s capacity to make a decision about his or her own assessment or treatment under the Act
- “forensic patient” means a person who has been admitted to the secure mental health unit under section 68 of the Act and who has not been discharged from the unit
- “frisk search”, of a patient, means a search that is conducted quickly by running the hands over the patient’s outer clothing, or passing a metal detection device over or close to the patient’s outer clothing, or examining anything worn or carried by the patient that he or she appears to have removed or discarded voluntarily, or passing a metal detention device over or close to anything the patient is wearing or carrying and that he or she appears to have removed or discarded voluntarily
- “Interim Treatment Order” means an Interim Treatment Order made under section 38 of the Act
- “involuntary patient” means a person who is subject to an Assessment Order, or to a Treatment Order
- “legal practitioner” means an Australian lawyer who holds a current practicing certificate, as defined in the Legal Profession Act 2007 (Tas)
- “medical practitioner” means a person registered under the Health Practitioner Regulation National Law (Tasmania) in the medical profession
“Mental Health Officer” means a person who has been approved as a Mental Health Officer under section 139 of the Act.

“Mental Health Tribunal” means the Mental Health Tribunal established under section 167 of the Act.

“mental illness” has the meaning given to the term by section 4 of the Act.

“MHO” means a Mental Health Officer.

“MHT” means the Mental Health Tribunal.

“Official Visitor” means a person for the time being holding an appointment under section 155(2) of the Act.

“ordinary search” means a search of a patient that is limited to requiring the patient to remove any coat jacket or similar outer garment, hat, shoes, boots or like footwear, socks, gloves or mittens, handbag, backpacks or other carrying items, requiring the patient to empty all or any of his or her pockets, and examining the item or items removed and the contents of them and, if applicable, the contents of the pockets so emptied.

“OV” means Official Visitor.

“parent”, of a child, means a person having, for the child, all of the responsibilities which, by law, a parent has in relation to his or her children.

“person with standing” means a person listed in Clause 2 or Clause 3 of Part 2 of Schedule 4 of the Act.

“POV” means Principal Official Visitor.

“President of the Tribunal” means the person appointed to be the President of the Mental Health Tribunal.

“Principal Official Visitor” means the person for the time being holding an appointment under section 155(1) of the Act.

“psychiatrist” means a medical practitioner who:

- is a Fellow of the Royal Australian and New Zealand College of Psychiatrists, or
- holds specialist registration in the specialty of psychiatry, or
- holds limited registration that enables the medical practitioner to practise the specialty of psychiatry.

“representative”, of a patient or prospective patient, means

- the patient’s guardian, or
- the patient’s Australian lawyer, or
- if the patient is a child and raises no objection, a parent of the patient, or
- any other person nominated by the patient to represent his or her interests.

“secure mental health unit” means a secure mental health unit approved for the Act under section 140 of the Act.

“supervision order” means a supervision order made under the Criminal Justice (Mental Impairment) Act 1999 (Tas) or Sentencing Act 1997 (Tas).
• “support person”, of a patient or prospective patient, means a person who provides the patient with ongoing care or support
• “this Report” (or the Report) means the report on the outcome of the Review
• “this Review” (or the Review) means the Review that the Minister for Mental Health and Wellbeing is required to complete under section 229 of the Act, within six years after the commencement of the Act
• “TLRI” means the Tasmania Law Reform Institute
• “treatment” has the meaning given to the term by section 6 of the Act
• “Treatment Order” means a treatment order made under Division 2 of Part 3 of Chapter 2 and includes an Interim Treatment Order made under section 38, unless stated otherwise
• “Urgent Circumstances Treatment” means treatment that is authorised under section 55 or section 87 of the Act
• “voluntary inpatient”, of an approved facility, means a person who has been admitted to the facility voluntarily to receive treatment for a mental illness and is receiving that treatment on the basis of informed consent.
Appendix 3 Mental Health Service Delivery Principles

The mental health service delivery principles are as follows:

(a) to respect, observe and promote the inherent rights, liberty, dignity, autonomy and self-respect of persons with mental illness

(b) to interfere with or restrict the rights of persons with mental illness in the least restrictive way and to the least extent consistent with the protection of those persons, the protection of the public and the proper delivery of the relevant service

(c) to provide a service that is comprehensive, accessible, inclusive, equitable and free from stigma

(d) to be sensitive and responsive to individual needs (whether as to culture, language, age, religion, gender or other factors)

(e) to emphasise and value promotion, prevention and early detection and intervention

(f) to seek to bring about the best therapeutic outcomes and promote patient recovery

(g) to provide services that are consistent with patient treatment plans

(h) to recognise the difficulty, importance and value of the role played by families, and support persons, of persons with mental illness

(i) to recognise, observe and promote the rights, welfare and safety of the children and other dependants of persons with mental illness

(j) to promote the ability of persons with mental illness to make their own choices

(k) to involve persons receiving services, and where appropriate their families and support persons, in decision-making

(l) to recognise families, and support persons, of persons with mental illness as partners, with mental health service providers, in the provision of their treatment and care to the extent that this is appropriate and consistent with their own wishes

(m) to respect the wishes of persons receiving services, and the wishes of their families and support persons, to the maximum extent consistent with the health and safety of those persons and the safety of others

(n) to promote and enable persons with mental illness to live, work and participate in their own community

(o) to operate so as to raise community awareness and understanding of mental illness and to foster community-wide respect for the inherent rights, liberty, dignity, autonomy and self-respect of persons with mental illness

(p) to be accountable

(q) to recognise and be responsive to national and international clinical, technical and human rights trends, developments and advances.
Appendix 4 Meaning of Mental Illness

For the purposes of this Act:

(a) a person is taken to have a mental illness if he or she experiences, temporarily, repeatedly or continually –

   (i) a serious impairment of thought (which may include delusions); or

   (ii) a serious impairment of mood, volition, perception or cognition; and

(b) nothing prevents the serious or permanent physiological, biochemical or psychological effects of alcohol use or drug-taking from being regarded as an indication that a person has a mental illness.

(2) However, under this Act, a person is not to be taken to have a mental illness by reason only of the person’s –

   (a) current or past expression of, or failure or refusal to express, a particular political opinion or belief; or

   (b) current or past expression of, or failure or refusal to express, a particular religious opinion or belief; or

   (c) current or past expression of, or failure or refusal to express, a particular philosophy; or

   (d) current or past expression of, or failure or refusal to express, a particular sexual preference or orientation; or

   (e) current or past engagement in, or failure or refusal to engage in, a particular political or religious activity; or

   (f) current or past engagement in a particular sexual activity or sexual promiscuity; or

   (g) current or past engagement in illegal conduct; or

   (h) current or past engagement in an antisocial activity; or

   (i) particular economic or social status; or

   (j) membership of a particular cultural or racial group; or

   (k) intoxication (however induced); or

   (l) intellectual or physical disability; or

   (m) acquired brain injury; or

   (n) dementia; or

   (o) temporary unconsciousness.
Appendix 5 Circumstances in which a Patient May be Taken under Escort

The circumstances in which a patient may be taken under escort are as follows:

- Under section 27 of the Act, an Assessment Order is authority for a police officer or MHO to take the patient under escort to ensure that he or she presents for assessment under the Order.

- Under section 42 of the Act, a Treatment Order is authority for a police officer or MHO to take the patient under escort to ensure that he or she presents for treatment under the Order.

- Under section 47A of the Act, a patient’s treating medical practitioner may seek to have a patient who requires admission to prevent possible harm taken under escort and involuntarily admitted to, and detained in, an approved facility under and in accordance with section 42 of the Act.

- Under section 59 of the Act, a direction to transfer an involuntary patient from one approved hospital to another is authority for an MHO to take the patient under escort, remove the patient from the transferring hospital or take the patient to another hospital.

- Under section 60 of the Act, an involuntary patient who is granted leave from an approved hospital may be required to be under escort during the leave or any part of the leave.

- Under section 61 of the Act, an involuntary patient who is absent from an approved hospital without leave, or who has taken leave but has failed to comply with a condition of the leave, the leave is cancelled or the period of leave expires and the patient has not returned to the approved hospital may be taken into protective custody and returned to the approved hospital by a police officer or MHO.

- Under section 64 of the Act, to effect the return of an involuntary patient who has been admitted to a secure mental health unit to an approved hospital, an authorised person may take the patient under escort, and remove the patient from the secure mental health unit and take the patient to the approved hospital.

- Under section 72 of the Act, a direction to transfer a forensic patient from one secure mental health unit to another is authority for an authorised person or police officer to take the patient under escort, remove the patient from the secure mental health unit in which he or she is being detained and take the patient to another secure mental health unit.

- Under section 73 of the Act, a direction to transfer a forensic patient from a secure mental health unit to a secure institution, an approved hospital or other institution is authority for an authorised person or police officer to take the patient under escort, and remove the patient from the secure mental health unit, and take the patient to the secure institution, approved hospital or other place.

- Under section 75 of the Act, a forensic patient who is not subject to a restriction order and who absconds from custody, or fails to comply with the terms and conditions of leave, or who is on leave of absence and the leave expires may be taken into protective custody by an authorised person or police officer and returned to the secure mental health unit.

- Under sections 78 and 82 of the Act, a forensic patient who is granted leave from a secure mental health unit may be required to be under escort during the leave or any part of the leave.

- Under sections 79 and 83 of the Act, a forensic patient whose leave has been cancelled may be apprehended and returned to the secure mental health unit under escort.
- Under section 116 of the Act, a forensic patient who is ordered to be brought before a judicial officer to give evidence may be taken under escort by an MHO, police officer or authorised person.

- Under section 117 of the Act, a forensic patient who is allowed to leave the secure mental health unit to attend the taking of a deposition may be taken under escort, removed from the secure mental health unit, taken to the place specified in the request for the taking of the deposition and returned to the secure mental health unit by an authorised person or police officer.
Appendix 6 Involuntary Patient Rights

The Act requires an involuntary patient to be given a Statement of Rights in the following circumstances:

- A person in protective custody who has been escorted to an approved assessment centre under section 18 of the Act is required to be given a Statement of Rights in a form approved by the CCP as soon as practicable after his or her arrival at the approved assessment centre. This requirement is set out in section 19 of the Act.

- An MHO or police officer who releases a person from protective custody is to give the person a copy of a record of matters related to the custody. This requirement is set out in section 21 of the Act.

- A medical practitioner who makes an Assessment Order for a person is required to give the person copy of the Order and a Statement of Rights in a form approved by the CCP as soon as practicable after the Order is made. This requirement is set out in section 29 of the Act.

- An AMP who affirms an Assessment Order is to give notice of this, and of any extension of the operation of the Order, to the patient. This requirement is set out in section 33 of the Act.

- An AMP who applies for a Treatment Order to be made or renewed is required to give the person in respect of whom the Order is sought a copy of the application, and a Statement of Rights in a form approved by the President of the Tribunal. These requirements are set out in sections 37 and 48 of the Act.

- The MHT is required to give a patient in respect of whom a Treatment Order has been made or renewed notice to this effect, and a copy of the Order, along with a Statement of Rights in a form approved by the President of the Tribunal. These requirements are set out in sections 45 and 48 of the Act.

- A medical practitioner who prepares or varies a treatment plan is required to give a copy of the plan and notice of (and reasons for) the variation to the patient. These requirements are set out in sections 53 and 54 of the Act.

- An AMP who authorises urgent circumstances treatment for an involuntary patient is required to tell the patient about the authorisation and to give a copy of the authorisation to the patient, along with a Statement of Rights in a form approved by the CCP. This requirement is set out in section 55 of the Act.

- A person who authorises seclusion or restraint is to give a copy of relevant records to the patient who has been secluded or restrained, along with a Statement of Rights in a form approved by the CCP. This requirement is set out in section 58 of the Act.

- The CCP or a delegate is required to give a copy of documentation relating to the patient’s transfer from one approved hospital to another to the patient being transferred, along with a Statement of Rights in a form approved by the CCP. This requirement is set out in section 59 of the Act.

- An AMP who approves, or who refuses to approve, leave for an involuntary patient is required to give a copy of the leave pass or notice of refusal to the patient, along with a Statement of Rights in a form approved by the CCP. Notice of an extension, variation or cancellation of leave is also to be given. These requirements are set out in section 60 of the Act.

- On authorising the admission of an involuntary patient to a secure mental health unit, or extending the period of admission, the CFP or delegate is to give notice of the admission (or extension), the reasons for the admission (or extension) and the period of detention (as extended if relevant) to the patient.
patient, along with a Statement of Rights relating to the patient’s rights as a forensic patient in a form approved by the CFP. This requirement is set out in section 64 of the Act.

• On authorising special psychiatric treatment, the MHT is to ensure that a copy of the authorisation is given to the patient before the treatment starts, together with a Statement of Rights in a form approved by the CCP. This requirement is set out in section 127 of the Act.

• The controlling authority of an approved hospital or approved assessment centre (or their delegate) is required to give a person a Statement of Rights in a form approved by the CCP whenever the person is admitted to the facility as a patient, and whenever the patient is discharged from the facility. This requirement is set out in section 129 of the Act.

• A mental health authority that withholds, defers the giving or qualifies information that is given to a patient or any private person about a patient in respect of any matter under the Act is required to give notice of the withholding, deferral or qualification, with reasons, to the patient. This requirement is set out in section 132 of the Act.

• On reviewing an Assessment Order, the MHT is required to give a copy of its determination to the patient along with a Statement of Rights in a form approved by the President of the Tribunal. This requirement is set out in section 180 of the Act.

• Within 24 hours of varying a Treatment Order, the MHT is required to give a copy of its determination to the patient, along with a Statement of Rights in a form approved by the President of the Tribunal. This requirement is set out in section 181 of the Act.

• Within 24 hours of correcting an order, determination, direction or other document under section 224A, the MHT must give a copy of the corrected document to the patient along with a Statement of Rights in a form approved by the President of the Tribunal.

Under section 62, every involuntary patient has the following rights:

• the right to have the restrictions on, and interference with, his or her dignity, rights and freedoms kept to a minimum consistent with his or her health or safety and the safety of other persons

• the right to have his or her decision-making capacity promoted, and his or her wishes respected, to the maximum extent consistent with his or her health or safety and the safety of other people

• the right, while in an approved hospital, to have access to current information about local, national and world events

• the right to be given clear, accurate and timely information about:
  o his or her rights as an involuntary patient
  o the rules and conditions governing his or her conduct in the hospital
  o his or her diagnosis and treatment

• the right, while in an approved hospital, to apply for leave of absence in accordance with the Act

• the right to have contact with, and to correspond privately with, his or her representatives and support persons and with Official Visitors

• the right, while in an approved hospital, to be provided with general health care

• the right, while in an approved hospital, to wear his or her own clothing (where appropriate to the treatment setting)
• the right, while in an approved hospital, not to be unreasonably deprived of any necessary physical aids
• the right, while in an approved hospital, not to be unreasonably deprived of any communication aid
• the right, while in an approved hospital, to be detained in a manner befitting his or her assessment, treatment or care requirements
• the right, while in an approved hospital, to practise a religion of the patient’s choice, to join with other patients in practising that religion and to possess such articles as are reasonably necessary for the practice of that religion (to such extent as is consistent with his or her health or safety, the safety of other persons and the management, good order and security of the hospital)
• the right, while in an approved hospital:
  o to practise customs in accordance with the patient’s cultural beliefs or cultural background, and
  o to join with other patients in practising those customs, and
  o to possess articles that are reasonably necessary for the practice of those customs
  to the extent that the practice of those customs is not contrary to any law and is consistent with the health and safety of the patient and other patients and the management, good order and security of the hospital
• the right, while in an approved hospital, to ask for and be given such reasonable help from hospital staff as will enable the patient to enjoy these rights.
Appendix 7 Forensic Patient Rights

The Act requires a forensic patient to be given a Statement of Rights in the following circumstances:

- On refusing a request from a forensic patient who is a prisoner or youth detainee to return to prison or youth detention, the CFP (or delegate) is to give notice of the refusal, along with a Statement of Rights in a form approved by the CFP. The requirement to do this is set out in section 70 of the Act.

- On transferring a forensic patient from a secure mental health unit to a secure institution, approved hospital or other premises, the CFP (or delegate) is to give a copy of the transfer direction to the patient, along with a Statement of Rights in a form approved by the CFP. The requirement to do this is set out in section 73 of the Act.

- On granting or refusing leave to a forensic patient who is subject to a restriction order, the MHT is to give the patient a copy of a record of the matter, along with a Statement of Rights in a form approved by the President of the Tribunal. The patient is also to be given other documentation associated with aspects of any leave that has been granted. The requirement to do this is set out in sections 78 and 79 of the Act.

- On granting or refusing leave to a forensic patient who is not subject to a restriction order, the CFP or treating medical practitioner is to give the patient a copy of a record of the matter, along with a Statement of Rights in a form approved by the CFP. The patient is also to be given other documentation associated with aspects of any leave that has been granted. The requirement to do this is set out in sections 82 and 83 of the Act.

- An AMP who authorises urgent circumstances treatment for a forensic patient is required to ensure that the patient is told of the authorisation as soon as possible after it is given and to give a copy of the authorisation to the patient, along with a Statement of Rights in a form approved by the CFP. The requirement to do this is set out in section 87 of the Act.

- The MHT is required to give a copy of any authorisation of treatment for a forensic patient to the patient, along with a Statement of Rights in a form that has been approved by the President of the Tribunal. The requirement to do this is set out in sections 88 and 91 of the Act.

- The controlling authority of a secure mental health unit is required to make a record of the use of force, or seclusion or restraint of a forensic patient and to give a copy of the record to the patient, together with a Statement of Reasons in a form that has been approved by the CFP. The requirement to do this is set out in section 96 of the Act.

- On authorising special psychiatric treatment for a forensic patient, the MHT is to ensure that a copy of the authorisation is given to the patient before the treatment starts, together with a Statement of Rights in a form approved by the CFP. This requirement is set out in section 127 of the Act.

- The controlling authority of a secure mental health unit (or their delegate) is required to give a person a Statement of Rights in a form approved by the CFP whenever the person is admitted to the facility as a patient, and whenever the patient is discharged from the facility. This requirement is set out in section 129 of the Act.

- A mental health authority that withholds, defers the giving or qualifies information that is given to a patient or any private person about a patient in respect of any matter under the Act is required to give notice of the withholding, deferral or qualification, with reasons, to the patient. This requirement is set out in section 132 of the Act.
Within 24 hours of reviewing an authorisation of treatment for a forensic patient, the MHT is to give a copy of its determination to the patient, along with a Statement of Rights in a form approved by the President of the Tribunal. The requirement to do this is set out in section 192 of the Act.

Within 24 hours of correcting an order, determination, direction or other document under section 224A, the MHT must give a copy of the corrected document to the patient along with a Statement of Rights in a form approved by the President of the Tribunal.

The further rights that forensic patients have are set out in section 108 and include:

- the right to have the restrictions on, and interference with, his or her dignity, rights and freedoms, kept to a minimum consistent with his or her health or safety and the safety of other people
- the right to have his or her decision-making capacity promoted, and his or her wishes respected, to the maximum extent consistent with his or her health or safety and the safety of other persons
- the right, while in a secure mental health unit, to have access to current information about local, national and world events
- the right to be given clear, accurate and timely information about:
  - his or her rights as a forensic patient
  - the rules and conditions governing his or her conduct in the secure mental health unit
  - his or her diagnosis and treatment
- the right, while in an SMHU, to apply for leave of absence in accordance with the Act
- the right to be provided with general health care
- the right to be provided with food that is adequate to maintain the patient’s health and wellbeing and with a varied diet
- the right to be provided with special dietary food if the CFP is satisfied that such food is necessary for medical reasons, because of the patient’s religious beliefs or because the patient is a vegetarian
- the right to be provided with basic clean clothing that is suitable for the climate, of suitable size and adequate to maintain the health of the patient
- the right to wear suitable clothing that the patient owns
- the right not to be unreasonably deprived of any necessary physical aids or communication aids
- the right to adequate toilet and sanitary arrangements
- the right to adequate light and air
- the right to practise a religion of the patient’s choice and, if consistent with the management, good order and security of the secure mental health unit, to join with other forensic patients in practising that religion and to possess such articles as are reasonably necessary for the practice of that religion
- the right:
  - to practise customs in accordance with the patient’s cultural beliefs or cultural background
  - to join with other patients in practising those customs
  - to possess articles that are reasonably necessary for the practice of those customs,
to the extent that the practice of those customs is not contrary to any law and is consistent with the health and safety of the patient and other patients and the management, good order and security of any approved facility that the person is in

• the right to have access to legal advice

• the right to be provided with information about the rules and conditions which will govern the patient’s behaviour in the secure mental health unit

• the right, while in the secure mental health unit, to ask for and be given the help that the patient needs to enable him or her to enjoy these rights.
Appendix 8 Record Keeping Requirements

The Act imposes the following record keeping requirements:

- An MHO or police officer who takes a person into protective custody is to make a record of the matter. An MHO or police officer who releases a person from protective custody is to make a record of the matter and provide a copy of that record, along with the record made when the person was taken into protective custody, to the person and to the CCP. These requirements are set out in section 21 of the Act.

- A medical practitioner who examines a person in protective custody is to make a record of the matter, place a copy of the record on the person’s clinical file and give the CCP a copy of the record. This requirement is set out in section 21 of the Act.

- A medical practitioner who makes an Assessment Order must document relevant matters using a CCP Approved Form. He or she must then give a copy of the Order to the patient, to the AMP who is likely to independently assess the patient or the controlling authority of the patient where the patient is, or is likely to be, assessed, and place a copy of the Order on the patient’s clinical record. These requirements are set out in sections 26 and 29 of the Act.

- An AMP who affirms an Assessment Order is required to give notice of the affirmation to the patient, the medical practitioner who made the Order, the CCP, the MHT, and the controlling authority of any approved facility that the patient is in, or is likely to be in. The AMP is also required to place a copy of the Instrument of Affirmation on the patient’s clinical record. These requirements are set out in section 33 of the Act.

- A medical practitioner who discharges an Assessment Order is required to complete a Discharge Paper, to give a copy of the discharge paper to the patient, the CCP, the MHT, and the AMP who was expected to do the assessment or the controlling authority of the approved facility where the assessment was to be done. The medical practitioner is also required to place a copy of the Discharge Paper on the patient’s clinical record. These obligations are set out in section 35 of the Act.

- An AMP who applies for a Treatment Order is required to complete an application. The application is required to be accompanied by a statement by the applicant affirming that (and explaining how) the person meets the treatment criteria and an indication of whether an Interim Treatment Order is needed. The applicant is also required to provide a copy of any Assessment Order to which the person is subject, to give a copy of the application to the person and to place a copy of the application on the person’s clinical record. These requirements are set out in section 37 of the Act.

- On making a Treatment Order, the MHT is required to give the patient notice of this and a copy of the Order. The MHT is also required to give notice that the Order has been made, and a copy of the Order to the AMP who applied for the Order, the treating medical practitioner, the controlling authority of any approved facility that the patient is in or is expected to be in, and the CCP. These requirements are set out in section 45 of the Act.

- An AMP who applies for the renewal of a Treatment Order is required to complete an application. The application is required to be accompanied by a copy of the Treatment Order, details of any recommended change in treatment or to the treatment setting, and a statement by the applicant affirming that (and explaining how) the patient continues to meet the treatment criteria and is expected to continue to meet those criteria for the period of renewal. The applicant is also required to give a copy of the application to the patient, the treating medical practitioner (if this is not the applicant), the CCP and the controlling authority of any approved facility that the patient is in, or is
expected to be in. Lastly the applicant is required to place a copy of the application and accompanying documentation on the patient’s clinical record. These obligations are set out in section 48 of the Act.

- On renewing a Treatment Order the MHT is required to give notice of the renewal to the patient, the applicant, the treating medical practitioner (if this is someone other than the applicant), the controlling authority of any approved facility that the patient is in (or is expected to be in) and the CCP. These obligations are also set out in section 48 of the Act.

- An AMP who discharges a Treatment Order is to complete a Discharge Paper and provide a copy of the Discharge Paper to the patient, the treating medical practitioner (if this is someone other than the AMP), the CCP and the MHT. He or she is also required to place a copy of the Discharge Paper on the patient’s clinical records. These obligations are set out in section 49 of the Act.

- A medical practitioner who prepares or varies a treatment plan is required to give a copy of the plan or details of the variation (and the reasons for any variation) to the patient and to the CCP, and to place a copy of the plan on the patient’s clinical record. These requirements are set out in sections 53 and 54 of the Act.

- An AMP who authorises urgent circumstances treatment for a patient is required to ensure the patient is advised of the authorisation as soon as possible after it is given and to give a copy of the authorisation to the relevant Chief Psychiatrist, the MHT and the patient and to place a copy of the authorisation on the patient’s clinical record. The requirement to do this for involuntary patients is set out in section 55 of the Act. The requirement to do this for forensic patients is set out in section 87 of the Act.

- A person who authorises seclusion or restraint is to make a record of the matter and give a copy of the record to the patient, the CCP and the MHT. A copy is also required to be placed on the patient’s clinical record. The requirement to do this for involuntary patients is set out in section 58 of the Act. The requirement to do this for forensic patients is set out in section 96 of the Act.

- The CCP or a delegate may direct an involuntary patient’s transfer from one approved hospital to another. A copy of the transfer direction is to be given to the patient, the controlling authority of each approved hospital, the treating medical practitioner and the MHT. A copy of the transfer direction is also to be placed on the patient’s clinical record. These obligations are set out in section 59 of the Act.

- An AMP who grants an involuntary patient leave is to document the leave in a leave pass and give a copy of the leave pass to the patient, the controlling authority of the relevant approved hospital, the patient’s escort (if applicable), the MHT and the CCP. The AMP is also required to place a copy of the leave pass on the patient’s clinical record. Any extension, variation or cancellation of the leave is to be similarly documented. These obligations are set out in section 60 of the Act.

- An AMP who refuses an application for leave for an involuntary patient is required to give notice of the refusal, with reasons, to the applicant and the patient, if the applicant was someone other than the patient. The AMP is also required to place a copy of the notice of refusal on the patient’s clinical records. These obligations are set out in section 60 of the Act.

- A patient’s treating medical practitioner is required to alert the MHT if an involuntary patient has taken leave from an approved hospital and the patient fails to comply with a condition of leave, or the leave is cancelled or if a period of leave that has been granted to the patient has expired and the patient has not returned to the approved hospital. These obligations also apply if a patient is absent without leave from an approved hospital. In these scenarios the patient’s treating medical
practitioner may also alert the Commissioner of Police of the circumstances. These obligations are set out in section 61 of the Act.

- On authorising the admission of an involuntary patient to a secure mental health unit, the CFP (or delegate) is to give notice of the admission, the reasons for the admission and the period of detention to the patient. The CFP (or delegate) is also required to give notice of the admission and the period of detention to the controlling authority of the secure mental health unit, the controlling authority of the approved hospital from which the patient is being transferred, the CCP and the MHT. Similar obligations apply to any decision by the CFP (or delegate) to extend the period of detention. These requirements are set out in section 64 of the Act.

- On accepting or refusing to accept a request from a forensic patient who is a prisoner or youth detainee to return to prison or youth detention, the CFP (or delegate) is required to make and keep a record of the request and the CFP's decision. On refusing a request the CFP (or delegate) is also required to give notice of the refusal to the patient and the MHT. These obligations are set out in section 70 of the Act.

- On directing that a forensic patient be removed from a secure mental health unit and transferred to a secure institution, approved hospital or other premises, the CFP (or delegate) is required to complete a transfer direction. The CFP or delegate is required to give a copy of the transfer direction to the patient, the controlling authority of the secure mental health unit, the person in charge of the secure institution, approved hospital, health service or other place to which the patient is transferred, the treating medical practitioner and the MHT. The CFP or delegate is also required to place a copy of the transfer direction on the patient's clinical record. These obligations are set out in section 73 of the Act.

- A person who applies for leave of absence for a forensic patient who is subject to a restriction order from an approved hospital is required to apply using an MHT form for this purpose. The CFP may determine the period of leave in the case of leave that has been granted for a particular purpose without a period being specified and in this case the CFP is required to make a record of the matter and give a copy of the record to the MHT, the patient and a range of other people, and to place a copy of the record on the patient's clinical record. The MHT is also required to make a record of leave that is granted or refused, and to give a copy of the record to the patient and other relevant people. These obligations are set out in section 78 of the Act.

- In the case of leave for a forensic patient who is not subject to a restriction order, the treating medical practitioner may determine the period of leave in the case of leave that has been granted for a particular purpose without a period being specified and in this case the treating medical practitioner is required to make a record of the matter and to give a copy of the record to the patient and a range of other people, and to place a copy of the record on the patient's clinical record. The CFP or delegate is also required to make a record of leave that is granted or refused, and to give a copy of the record to the patient and other relevant people. These obligations are set out in section 82 of the Act.

- On cancelling leave that has been granted to a forensic patient, the person who has cancelled the leave is required to make a record of the cancellation and give a copy of the record to a range of people including the MHT (if the patient is subject to a restriction order) and the CFP (if the patient is not subject to a restriction order) and to place a copy of the record on the patient's clinical file. These obligations are set out in sections 79 and 83 of the Act.

- On applying to the MHT for authorisation of treatment for a forensic patient, an AMP must complete a written form. On authorising treatment for a forensic patient, the MHT is to document the authorisation and give a copy of the authorisation (or advice that authorisation has been given, in the
case of an interim Treatment Order) to the patient, the applicant and the CFP. These requirements are set out in sections 88 and 91 of the Act.

- The controlling authority is to make a record of the application of force to a forensic patient and give a copy of the record to the patient, the CFP and the MHT, and to place a copy of the record on the patient’s clinical record. The requirement to do this is set out in section 96 of the Act.

- On authorising a search, the CFP or controlling authority is required to document the authorisation. The requirement to do this is set out in section 111.

- On authorising special psychiatric treatment, the MHT is required to ensure that the authorisation contains certain information and that a copy of the authorisation is given to the patient and to the relevant Chief Psychiatrist. The requirement to this is set out in section 127 of the Act.

- On giving a patient special psychiatric treatment, a treating medical practitioner is to make a record of the matter, place a copy of the record on the patient’s clinical record and give a copy of the record to the relevant Chief Psychiatrist and the MHT. The requirement to do this is set out in section 128 of the Act.

- On withholding, deferring or qualifying information, a mental health authority is to make a note about the withholding, deferral or qualification on the patient’s clinical record, and give notice of the withholding, deferral or qualification of the information, with good reasons, to the patient, the patient’s representative and the MHT and the relevant Chief Psychiatrist, if the mental health authority is not the Chief Psychiatrist. The requirement to do this is set out in section 132 of the Act.

- On reviewing an Assessment Order, the MHT is to give a copy of its determination to the patient, the CCP and the controlling authority (if the Order is still in effect and requires the patient’s admission to an approved facility). The requirement to do this is set out in section 180 of the Act.

- On varying a Treatment Order, the MHT is to give a copy of its determination to the patient, the controlling authority of an approved hospital (if the Order has required or will require the patient’s admission to an approved hospital), the CFP and the controlling authority of the relevant secure mental health unit (if the patient is also a forensic patient), and in any other case, the CCP. The requirement to do this is set out in section 181 of the Act.

- On reviewing the authorisation of treatment for a forensic patient, the MHT is to give a copy of its determination to the patient, the controlling authority of the relevant secure mental health unit and the CFP. The requirement to do this is set out in section 192 of the Act.

- On sedating a patient who is being transported by ambulance under the Act, an approved MHO or approved medical officer is required to give the CCP a report of the matter. The report is to be in an approved form and to include the matters referred to in section 212.

- On correcting an order, determination, direction or other document, the MHT must give a copy of the corrected document to the patient, the controlling authority of an approved hospital (if the patient has been, is or will be admitted to, or detained in, an approved hospital), the CFP and controlling authority of the relevant secure mental health unit (if the patient is a forensic patient), and in any other case, the CCP. The requirement to do this is set out in section 224 of the Act.

- The MHT is to ensure that a party to any MHT proceedings is given reasonable notice of each hearing held in the course of those proceedings. The MHT may also notify other people as it thinks fit in the circumstances. The requirement to do this is set out in Schedule 4 Part 2 of the Act.
• The MHT is required to make and keep a record of each of its proceedings. The obligation to do this is set out in Schedule 4 Part 2 of the Act.

• The MHT is required to provide parties to proceedings with a statement of reasons for making any determination in or in respect of those proceedings on application of a party to the proceedings. The requirement for the MHT to do this is set out in Schedule 4 Part 6 of the Act.
Appendix 9 Chief Psychiatrist Approved Forms

The CCP has approved forms for the following matters:

- Decision-making capacity (CCP Approved Forms 2A and 2B)
- Protective Custody (CCP Approved Form 4)
- Assessment Orders (CCP Approved Form 6)
- Treatment Plans (CCP Approved Form 7)
- Urgent Circumstances Treatment (Involuntary Patients) (CCP Approved Form 8)
- Seclusion (Involuntary Patients) (CCP Approved Form 9)
- Restraint (Involuntary Patients) (CCP Approved Form 10)
- Leave (Involuntary Patients) (CCP Approved Forms 11, 12A, 12B and 12C)
- Involuntary Patient Transfer Between Hospitals (CCP Approved Form 13)
- Admission of an involuntary patient to hospital following failure to comply with a Treatment Order (CCP Approved Form 22)
- Admission of an involuntary patient to hospital to prevent possible harm (CCP Approved Form 23)
- Involuntary Patient Escort to Hospital (CCP Approved Form 24).

The CFP has approved forms for the following matters:

- Urgent Circumstances Treatment (Forensic Patients) (CFP Approved Form 8)
- Seclusion (Forensic Patients) (CFP Approved Form 9)
- Restraint (Forensic Patients) (CFP Approved Form 10)
- Leave (Forensic Patients) (CFP Approved Forms 12A, 12B and 12C)
- Search and Seizure (CFP Approved Form 16)
- Forensic Patient Transfer to Hospital (CFP Approved Form 17)
- Cancellation or Suspension of Visits (CFP Approved Form 18)
- Forensic Patient Request to Return to Prison/Youth Detention (CFP Approved Forms 20A and 20B).
Appendix 10 Mental Health Tribunal Review Functions

The MHT’s review functions are as follows:

- Section 180 relates to the review of Assessment Orders. Under that section, the MHT may review the making of an Assessment Order at any time on its own motion or on the application of any person with the necessary standing.

- Section 181 relates to the review of Treatment Orders. Under that section, the MHT must review a Treatment Order within 60 days, within 180 days, and at subsequent 180-day intervals, after the Order is made if it is still in effect at the relevant time, and within three days of being notified that a patient who is subject to a Treatment Order has been admitted to an approved hospital for failure to comply with the Order. The section also confirms the MHT’s capacity to review an Order at any other time on its own motion or on the application of any person with the necessary standing, and to vary a Treatment Order at any time on its own motion, on the application of any AMP, or on the application of any person with the necessary standing.

- Section 182 relates to the review of the admission of an involuntary patient to a secure mental health unit. The section requires the MHT to review a patient’s admission, and any extension of the admission, within three days of being notified. As with other review, the MHT may also review the admission or extension at any other time on the MHT’s own motion or on the application of any person with the necessary standing.

- Section 183 relates to the review of a decision by the CFP to refuse to allow a prisoner or youth detainee who has been detained in the secure mental health unit on the prisoner or detainee’s own request to return to prison or youth detention. Under the section, the MHT may review the refusal on its own motion or on the application of any person with the necessary standing, and a review conducted on the application of any person with the necessary standing must occur within 7 days.

- Section 184 relates to the review of the status of voluntary inpatients. Section 184 requires the MHT to review a patient’s status once he or she has been a voluntary inpatient for a period of six months continuously, with the review commencing within 30 days of the six-month period passing and at six monthly intervals thereafter for so long as the person remains a voluntary inpatient. The MHT may additionally review the patient’s status at any other time on the MHT’s own motion or on the request of any person with the necessary standing.

- Section 185 relates to the review of the admission of prisoners or youth detainees to the secure mental health unit. The section requires the MHT to review an admission of this kind within seven days of being notified of the admission. The MHT may also review an admission at any other time on the MHT’s own motion or on the application of any person with the necessary standing.

- Section 186 relates to the review of urgent circumstances treatment. Under the section, the MHT may conduct a review at any time on its own motion or on the application of any person with the necessary standing, even if the treatment has ended. Actions available to the MHT following a review include recommending that a patient be examined against the treatment criteria to see if a Treatment Order needs to be made and in the case of a forensic patient, recommending that an AMP seek the MHT’s authorisation of treatment in respect of the patient.

- Section 187 relates to the review of seclusion and restraint. Under the section, the MHT is required to do a review on the application of any person with the necessary standing and may do so on its own motion at any time, even if the seclusion has ended.
• Section 188 relates to the application of force to a forensic patient. As with seclusion and restraint, the section requires the MHT do to a review on the application of any person with the necessary standing and may do so on its own motion at any time, even if the application of force has ended.

• Section 189 governs review by the MHT of the withholding of information from a patient. Under the section, the MHT is required to conduct a review on the application of any person with the necessary standing and may do so on its own motion at any time.

• Section 190 governs review by the MHT of involuntary and forensic patient transfer within Tasmania. The section requires the MHT to conduct a review on the application of any person with the necessary and enables the MHT to conduct a review on its own motion at any other time.

• Section 191 governs the review of matters relating to patient leave. As with other sections, section 191 requires the MHT to do a review on the application of any person with the necessary standing and provides the MHT with discretion to conduct a review on its own motion at any other time, regardless of whether the leave is prospective, has commenced or concluded, or has been varied.

• Section 192 applies to the review of forensic patient visiting, telephone and correspondence rights. The MHT is required to conduct a review on the application of a person with the necessary standing and may do a review on its own motion at any other time, regardless of whether the relevant rights have been exercised.

• Section 192A applies to the review of the authorisation of treatment for forensic patients. Under the section, the MHT must review an authorisation within 60 days and 180 days after it is made, and at 180-day intervals thereafter, if the authorisation is still in effect at that time. The MHT may also review an authorisation at any other time on its own motion or on the application of any person with the necessary standing.

• Section 193 governs the review of any decision or matter that is not explicitly covered by the Act. The MHT may do reviews of this kind on its own motion at any time or on the application of the person with the necessary standing.