Urgent Circumstances Treatment

Chief Civil Psychiatrist Clinical Guideline 8

Provisions to Which the Guideline Relates

Mental Health Act 2013 – sections 6, 15, 16, 55 and Schedule 1 (extracted at Appendix 1).

Preamble

The framework established by the Act enables an involuntary patient to be given treatment:

- With informed consent, or
- If the treatment is authorised by a Treatment Order, or
- If the treatment is urgent circumstances treatment – if the treatment is authorised under section 55 of the Act.

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 the assessment and treatment of persons with mental illness.

The Act provides for Assessment Orders. Assessment Orders provide authority for a patient to be assessed, without informed consent, by an approved medical practitioner to confirm whether the patient meets the assessment criteria and to determine if the patient also meets the treatment criteria. Assessment Orders do not, however provide authority for a patient to be given any treatment.

The Act also provides for Treatment Orders. Treatment Orders provide authority for a patient 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 patient to be given treatment that is urgently needed in the patient's best interests, without informed consent or the need for Tribunal authorisation, in circumstances where achieving the necessary treatment outcome would be compromised by waiting for the urgent circumstances treatment to be authorised by the Tribunal (or by a member of the Tribunal on an interim basis).

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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.

Purpose

This Clinical Guideline is intended to help controlling authorities, people in charge of community mental health premises, medical practitioners, nurses and other staff members of approved hospitals, approved assessment centres and community mental health teams in the exercise of responsibilities relating to the authorisation of urgent circumstances treatment for involuntary patients under the *Mental Health Act 2013*, and related matters.

The Guideline is designed to ensure that urgent circumstances treatment is authorised and given appropriately, safely and in a manner that is respectful of the dignity and rights of patients.

Failure by an individual to have regard to this Clinical Guideline is not an offence but may, particularly if it leads to unfavourable patient outcomes that might otherwise have been avoided or if there is a history of such disregard, constitute proper grounds for instating professional or occupational disciplinary action against that individual.

Guideline

I, Professor Kenneth Clifford Kirkby, being and as the Chief Forensic Psychiatrist, pursuant to sections 151 and 153 of the *Mental Health Act 2013* and section 22 of the *Acts Interpretation Act 1931* hereby:

1. Revoke all previous directions (clinical guideline) issued under section 152 of the *Mental Health Act 2013* with respect to the exercise of responsibilities in relation to authorising urgent circumstances treatment with effect from 11.59 pm on 30 June 2017; and

2. Issue the following direction (clinical guideline) to controlling authorities (and delegates) and authorised persons exercising responsibilities in relation to authorising urgent circumstances treatment under the *Mental Health Act 2013*, and related matters, with effect from 12.00 am on 1 July 2017.

What is Urgent Circumstances Treatment?

The Act defines treatment to mean the professional intervention necessary to prevent or remedy mental illness; or to manage and alleviate, where possible, the ill effects of mental illness; or to reduce the risks that persons with mental illness may, on that account, pose to themselves or others; or to monitor or evaluate a person's mental state.

This professional intervention does not extend to special psychiatric treatment or general health care. It also does not include seclusion, chemical restraint, mechanical restraint or physical restraint.

Urgent circumstances treatment is treatment that is authorised by an approved medical practitioner as being urgently needed in the patient's best interests under section 55 of the Act.

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Authorising Urgent Circumstances Treatment

An approved medical practitioner may authorise urgent circumstances treatment as being urgently needed in the patient's best interests only if the approved medical practitioner 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 Tribunal (or by a member of the Tribunal on an interim basis). An approved medical practitioner may authorise the treatment if, and only if, he or she has concluded from an examination that:

(a) the patient has a mental illness that is generally in need of treatment, and

(b) the urgent circumstances treatment is necessary for the patient's health or safety or the safety of other people, and

(c) the urgent circumstances treatment is likely to be effective and appropriate in terms of the outcomes referred to in section 6(1) of the Act, and

(d) achieving the necessary treatment outcome would be compromised by waiting for the urgent circumstances treatment to be authorised by the Tribunal, or by a member of the Tribunal on an interim basis.

Reducing the Use of Urgent Circumstances Treatment

While urgent circumstances treatment is a means of ensuring that a patient is given treatment which is needed when it is needed, it can also be a source of distress not only for the patient but also for support persons, representatives, other patients, staff and visitors.

Wherever possible, alternative, less restrictive ways of managing a patient's treatment needs should be pursued, and the use of urgent circumstances treatment minimised.

Inclusion of Patients and Support Persons

There may be a greater chance of avoiding the need to give urgent circumstances treatment if inpatient care involves patients, their representatives and support persons.

It should not be assumed that patients, or their representatives or support persons will be aware that the person may be given urgent circumstances treatment while an involuntary patient.

Every effort should be made to provide patients, their support persons and representatives with information about urgent circumstances treatment and its authorisation and application. In practice this may be achieved through providing patients with access to this document and to Chief Civil Psychiatrist Standing Order 8: Urgent Circumstances Treatment.

Staff should listen to concerns expressed by patients, and by their representatives and support persons about urgent circumstances treatment and should provide information which may address concerns, and answers to any questions asked, whenever needed.

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While it is appropriate to provide information to representatives and support persons in this way care should be taken to ensure that information which is specific to the patient and their treatment is provided to others only when the patient consents.

Care Planning to Minimise the Use of Urgent Circumstances Treatment

Care planning that takes into consideration individual patient needs, preferences and experiences of which treatments are most effective should occur for all patients.

In circumstances where urgent circumstances treatment is likely to be necessary, planning should consider the individual's safety and care needs while being given urgent circumstances treatment, particularly for patients who are assessed as likely to present with acutely disturbed or aggressive behaviours, for those who require repeated episodes of urgent circumstances treatment or where there is considered to be a need to give urgent circumstances treatment to a person who is extremely disturbed immediately after the patient's arrival at an approved assessment centre or approved hospital.

Care planning should also involve:

- Identifying mental and physical health problems and risks, and how they are to be managed
- Determining the frequency and nature of clinical observations required to be performed. This may include physical (respiration, pallor or cyanosis, posture, level of consciousness, motor activity, blood pressure and pulse) and mental state (pattern and content of speech, thought content, mood, affect, concentration, attention and level of motor activity) observations
- Identifying the time and frequency of medical examinations required to be performed
- Establishing when the care plan itself should be reviewed.

Where urgent circumstances treatment involves medication being given in large doses or the giving of medication which is likely to be in effect some hours later, it is good clinical practice to obtain a second opinion or hold a case conference to review the patient's management as soon as practicable.

Diagnosis and Management of Underlying Conditions

Patients whose symptoms fail to respond to a full range of clinical interventions pose particular clinical challenges. Careful consideration and management may be required.

A thorough review of the patient's history, treatments attempted and their duration, and doses of medication administered and the patient's responses to these should be undertaken by the treating team, and may be the subject of a case conference. A second opinion external to the treating team may also be sought.

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Managing Urgent Circumstances Treatment

Communication Considerations

A patient for whom urgent circumstances treatment is authorised should be told that he or she is being given urgent circumstances treatment, and should be informed of the duration of the treatment. Patients should also be informed of any determinations to seek a new Treatment Order or variation to an existing Treatment Order and of the nature of the treatment for which approval has been sought.

Attempts should be made to inform a patient's representatives and/or support persons that the patient has been given urgent circumstances treatment as soon as practicable after the treatment has been given, and of the duration of the treatment. Information and support should be offered to representatives and/or support persons as and when needed.

The Act requires a patient for whom urgent circumstances treatment has been authorised to be advised that authorisation has been granted and to be given a copy of the authorisation and a statement of rights as soon as practicable after the decision is made to give the treatment. A copy should also be attached to the patient clinical record and a copy sent to the Chief Civil Psychiatrist and the Mental Health Tribunal.

These requirements may be discharged prior to the treatment being given, while the patient is subject to the treatment which has been authorised, or as soon as practicable thereafter.

Consideration should be given to having a member of nursing staff read the statement to a patient who is significantly unwell and/or considered otherwise unlikely to fully understand the content of any written statement that is provided, pending the provision of a written statement to the patient once this is considered to be clinically appropriate.

Clinical Considerations

A patient for whom urgent circumstances treatment is considered to be necessary should be thoroughly medically assessed. This should occur either prior to, or as soon as possible after urgent circumstances treatment is authorised.

Particular emphasis should be placed on seeking a history of the presentation from the patient and their support persons, as well as other relevant/significant people. This should include information about the possible ingestion of alcohol, illicit drugs, over-the-counter medication and prescription medication that may have been ingested as overdose, deliberate or accidental. Information on medication prescribed should also be obtained.

The assessment should be as thorough as the circumstances allow and should include an assessment of the risk to the patient from deliberate or accidental self-harm.

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Medication Considerations

In circumstances where it is difficult to thoroughly medically assess the patient, the risk of adverse effects from medication is greatly increased. Factors to be taken into account in deciding whether or not prescribed medication should be given include the safety and wellbeing of the patient, any medication already prescribed and administered and the likely interaction of these with the prescribed medication proposed to be given, the nature of the medication given as urgent circumstances treatment and the likely interaction of this with the prescribed medication proposed to be given, the patient's ongoing management needs, whether giving the medication is consistent with achieving the best treatment outcomes in the shortest possible time, and the safety of other patients and staff if the medication is given or is not given.

Medical staff prescribing for people who are or who may be given urgent circumstances treatment must be familiar with the possible adverse effects of any medication prescribed and the cumulative effects of the medication from repeated administration. Prescribing psychotropic medication should be in accordance with accepted guidelines.

Staff should be aware that the use or withdrawal from benzodiazepines, tobacco or other drugs may heighten anxiety and aggression in some people.

Use of Security Personnel

Security staff involved in any restraint procedures which may be associated with the giving of urgent circumstances treatment should be under the direct authority and supervision of the senior registered nurse on duty or medical practitioner present, at all stages of a patient's restraint.

Any concerns about the individual practices of staff involved in these procedures should be escalated to a senior manager.

Special Considerations

Patients with a History of Trauma

The giving of urgent circumstances treatment may trigger extreme responses from some individuals, including those who have a history of trauma, particularly if the giving of the treatment involves the use of restraint. Responses may include flashbacks, hallucinations, dissociation, aggression, self-injury and depression.

Patients with a history of trauma who are given urgent circumstances treatment may feel they are being punished. They may be confused by the use of force by staff and may feel unsafe and unprotected from harm. They may also feel bitter and angry.

Research suggests a very high prevalence of traumatic experiences in persons who receive mental health services. A majority of adults and children in inpatient psychiatric treatment settings present with trauma histories and there are certainly others whose trauma histories haven't become known yet.

For this reason, as a universal precaution, it should be presumed that every person in a treatment setting has been exposed to trauma.

Gender Safety and Sensitivity

Given the high incidence of previous experiences of trauma among involuntary patients and given that practices such as urgent circumstances treatment may potentially retrigger previous experiences of trauma in some people, services should ensure that staff demonstrate sensitivity to individual patient's needs and wellbeing in giving treatment in these circumstances, particularly with regard to gender.

For example, the giving of urgent circumstances treatment may be experienced by the patient as particularly traumatic or humiliating where nursing and security staff are predominantly male or female. As such, different patients may have different preferences about the gender of staff involved in the intervention. Where possible, the patient's preferences should be sought and responded to.

Consideration should also be given to the possibility of pregnancy in female patients and the implications of this, especially for the use of medications.

Children and Adolescents

While the parent or guardian of a young person should be informed that urgent circumstances treatment has been given as soon as practicable after the event, and involved in the debriefing process wherever possible, a decision to involve a parent or guardian must take into account the child's capacity to consent to their involvement, and the child's views about this. This may involve considering whether or not the child is capable of fully understanding the nature and consequences of the decision to involve the parent and the child's ability to communicate his or her decision.

Older Persons

Changes in mental state in older people – particularly those with dementia – may be a result of medical illness, physical discomfort, sensory impairment or the presence of unmet needs which cannot easily be communicated to staff.

Particular care should be given to supporting older patients to communicate through use of short, clear sentences in a lower tone of voice, employing active listening skills to hear what the patient may be trying to communicate.

The possibility of delirium must be considered in the assessment of any older patient who is becoming agitated, distressed or confused or for whom urgent circumstances treatment is being considered. Matters which may be associated with delirium such as hypoxia, hypertension, hypoglycaemia, major electrolyte disturbance, infection, urinary retention, constipation and faecal impaction along with pain, thirst, hunger and alcohol withdrawal syndrome should considered along with any other clinical factors that may require management including depression or anxiety and any new neurological deficits.

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At times a patient's distress may be reduced through the application of comfort factors including positioning, immobility, provision of communication aids including hearing aids or glasses, activity to alleviate boredom, toileting needs, thirst, loneliness or lack of activity, or modification of environmental factors such as noise, temperature or lighting.

The vulnerability of older patients – particularly the increased risk of falls - should be a consideration in any decision to give urgent circumstances treatment and should be taken into account in the administration of the treatment.

Communication with Patients from Culturally and Linguistically Diverse Backgrounds

Urgent circumstances treatment may be more traumatic and potentially more dangerous for those who are unable to understand what is happening or unable to communicate their questions or concerns. The use of professional interpreters must be considered in these situations.

Patients may perceive or interpret any use of force associated with administering the treatment differently depending on their cultural backgrounds and personal experiences as a refugee or a survivor of abuse or torture.

It is important to be aware that communication problems in themselves may lead to unnecessary interventions. Special care should be taken to achieve effective communication, first to avert the use of urgent circumstances treatment, if possible, and second, to minimise the trauma of the intervention to the patient both during and after the intervention. The use of interpreters and availability of communication aids whilst the patient is subject to the effects of the treatment should be considered in these situations.

Every effort should be made to understand and respond to cultural sensitivities by, for example, providing language services and by taking into account the gender of direct care staff.

Communication with Patients with Sensory Impairment

Urgent circumstances treatment may also be more traumatic and potentially more dangerous for patients who may be unable to understand what is happening or unable to communicate their questions or concerns due to sensory impairment.

Special care should be taken in these situations to achieve effective communication, first to avert the use of urgent circumstances treatment, if possible, and second, to minimise the trauma of the intervention to the patient both during and after the intervention. The use of support persons or representatives who are familiar with the communication needs of the patient and the availability of communication aids required by the patient to communicate on a daily basis should be considered in these situations.

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Observation and Examination Requirements

Once the decision has been made to give urgent circumstances treatment, careful assessment of the patient's safety needs is essential, together with clinical monitoring, support and review.

Clinical Observation Requirements

Patients who have been given urgent circumstances treatment should be regularly clinically observed. This process should involve:

- Monitoring the patient's vital signs including the patient's pulse, respiration, blood pressure, posture, muscle tone, level of consciousness and comfort level, and
- Mental status observation including the patient's pattern and content of speech, attention, level of motor activity and orientation.

Particular emphasis should be placed on seeking the patient's history at the first observation. This should include information about the possible ingestion of alcohol or illicit drugs, and of deliberate or accidental overdose of prescribed medications, and any history of suicide attempts by the patient, and involve:

- A review of the patient's physical and mental health status, and
- An assessment of the adverse effects of medication, and
- A reassessment of the medication prescribed, and
- An assessment of the risk to the patient from deliberate or accidental self-harm, and
- An assessment of the potential or likely need for repeat application of urgent circumstances treatment.

Occasionally a patient whose mental state and reasoning is profoundly impaired by their illness is admitted to an inpatient unit. Patients in this state may be unable or unwilling to give coherent responses to questions and/or are aggressively opposed to being physically examined. While this makes adequate assessment difficult, as thorough an assessment of the patient as is possible should take place before any medication is administered.

Staff must be alert to the possibility that the patient who appears to be asleep may actually be unconscious. Where a patient appears to be asleep while under the effects of urgent circumstances treatment, clinical staff should be alert to and assess the level of consciousness and respirations of the patient to exclude the possibility of an altered level of consciousness or respiratory distress.

Communication with the Treating Team

A senior member of the treating team should be informed if a patient is given urgent circumstances treatment as soon as is reasonably practicable in order to inform ongoing management decisions associated with the patient.

Clear systems and processes should be in place to communicate to relevant clinical staff across successive shifts. In particular, details regarding the reasons for the use of urgent circumstances treatment, the current plan and previous treatments provided should be clearly communicated at handover points and be available in the clinical record. The clinical record should contain up-to-date documentation such as risk

assessments, restraint management or safety plans, observation charts, medical reviews and communication with other parties - for example, support persons.

Once Urgent Circumstances Treatment Is Completed

Post-Treatment Patient Support

Although urgent circumstances treatment may be used for sound clinical reasons, it is a potentially traumatic intervention that requires sensitivity and skill in its management.

Once the patient is settled and willing to discuss the incident leading to the authorisation of urgent circumstances treatment, the patient's understanding and experience of the incident should be explored and the reasons urgent circumstances treatment was applied for and other interventions deemed ineffective or inappropriate explained to the patient.

The patient should be allowed to discuss their experience of being given urgent circumstances treatment and of any reviews conducted.

Staff must be aware that the purpose of a post-urgent circumstances treatment discussion with the patient is to provide an opportunity for the individual's experience of the episode to be discussed. Attempts by staff to justify the decision to apply for or authorise urgent circumstances treatment may be counterproductive.

The patient should be given a choice as to who they would like to discuss their experience with, wherever possible.

Consideration should be given to the sensitive reintegration of the patient into the general inpatient population because patients might consider urgent circumstances treatment to be embarrassing or humiliating.

Clinical staff members also need to be aware of how the patient and others in the inpatient unit or community team are affected by the use of urgent circumstances treatment. Staff should offer information on urgent circumstances treatment to visitors and to other people (including other patients) who have witnessed the treatment.

Documentation and Review

Following the cessation of an instance of urgent circumstances treatment, a formal review meeting should occur as soon as possible. This should involve at least the unit manager, senior registered nurses and consultant psychiatrist.

Wherever possible, the patient and his or her carers and family members should be encouraged to participate in the relevant parts of the review process.

The aim of the review meeting is to:

- Review the event including the lead up to the authorisation of urgent circumstances treatment
- Review compliance with the Act

- Review system-wide management issues that may need addressing to prevent further authorisations of urgent circumstances treatment
- Update clinical risk assessments relating to the patient and the patient's care plan
- Identify any changes that may need to be made to the patient's treatment plan and/or Treatment Order.

Any systemic issues identified in the formal review are to be forwarded to the relevant safety and quality improvement committee for attention.

Guidance for Controlling Authorities

Controlling authorities of approved assessment centres, approved hospitals and community mental health premises should consider the requirements of the *Mental Health Act 2013* and this Guideline when designing or designating rooms or areas in which patients may be given urgent circumstances treatment.

Controlling authorities should also ensure that staff members who are required, or potentially required, to exercise functions and powers relating to urgent circumstances treatment are educated and trained on the safe use of medications given in this circumstance and on the requirements of the *Mental Health Act 2013* as it relates to urgent circumstances treatment and associated processes. This includes contracted security personnel.

Controlling authorities should consider including the following matters within the scope of quality assurance and review activities:

- The extent to which staff know how to apply the framework established by the Act and are aware of this Guideline, relevant Chief Civil Psychiatrist Standing Orders and any local policies and procedures associated with urgent circumstances treatment
- The reasons for urgent circumstances treatment being authorised
- The prolonged or repeated use of urgent circumstances treatment
- Risk assessments conducted prior to and during urgent circumstances treatment
- Injuries or other incidents occurring in the lead up to the authorisation of urgent circumstances treatment, or while the patient is subject to urgent circumstances treatment
- The use and effectiveness of strategies to reduce the use of urgent circumstances treatment
- The use of medication in respect of patients who are given urgent circumstances treatment
- Patient and support person perceptions of urgent circumstances treatment.

Findings from activities conducted should be used to inform the development of training programs for staff.

Guidance for Clinical Staff

Staff members working within approved assessment centres, approved hospitals and community mental health premises should ensure that they have a sound knowledge of the *Mental Health Act 2013*, this

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Guideline, relevant Chief Civil Psychiatrist Standing Orders and of any local policies and procedures relating to the use of urgent circumstances treatment which may be in place from time to time.

Staff members who are directly involved in the provision of patient care should ensure that they receive specific training in how to ensure that urgent circumstances treatment is applied for, authorised and used minimally and safely.

Staff likely to be involved in the provision of urgent circumstances treatment should also ensure that they receive training in observation and monitoring of patients who have been given urgent circumstances treatment and in recognising signs of mental and physical distress in a patient who has been given urgent circumstances treatment.

At the completion of training staff should be able to demonstrate an understanding of:

- Legislation governing the use of urgent circumstances treatment in Tasmania
- How patients experience urgent circumstances treatment
- The impact of their own behaviours and attitudes on patients

Professor Kenneth Clifford Kirkby

Chief Civil Psychiatrist

Date: 1 July 2017

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Appendix 1: Relevant Legislative Provisions

3. Interpretation

adult *means a person who has attained the age of 18 years*

approved assessment centre *means an assessment centre that is approved under section 140 of the Act*

assessment order *means an assessment order made under Division 1 of Part 3 of Chapter 2 of the Act*

approved facility *means an approved hospital, an approved assessment centre or a secure mental health unit.*

approved hospital *means a hospital approved under section 140 of the Act.*

approved medical practitioner *means a person who has been approved by a Chief Psychiatrist under section 138 of the Act.*

Chief Civil Psychiatrist *means the person for the time being holding or acting in the office referred to in section 143 of the Act. The Chief Civil Psychiatrist has responsibility for ensuring that the objects of the Act are met in respect of patients other than forensic patients or persons who are subject to supervision orders, and for the running of approved facilities other than secure mental health units.*

child *means a person who has not attained the age of 18 years*

controlling authority *means –*

> *(a) for an approved facility run by or on behalf of the State, the Secretary, Department of Health and Human Services; and*
>
> *(b) for any other approved facility, the person for the time being in overall charge of the day-to-day clinical management of that facility*

general health care *means medical, dental or other health treatment not primarily aimed at the treatment or alleviation of mental illness*

involuntary patient *means a person who is subject to an assessment order or treatment order*

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*

***representative**, of a patient or prospective patient, means –*

(a) the patient's guardian; or

(b) the patient's Australian lawyer; or

(c) if the patient is a child and raises no objection, a parent of the patient; or

(d) any other person nominated by the patient to represent his or her interests

***statement of rights** means a written statement that sets out and succinctly explains, in plain language, what rights a patient or prospective patient has in the particular circumstances under this Act in which he or she is required to be given such a statement*

***support person**, of a patient or prospective patient, means a person who provides the patient with ongoing care or support*

***treating medical practitioner** means the medical practitioner who is responsible for a patient's treatment or proposed treatment*

***treatment order** means a treatment order made under Division 2 of Part 3 of Chapter 2 of the Act, and includes an interim treatment order made under section 38 of the Act.*

6. Meaning of treatment

(1) For the purposes of this Act, treatment is the professional intervention necessary to –

(a) prevent or remedy mental illness; or

(b) manage and alleviate, where possible, the ill effects of mental illness; or

(c) reduce the risks that persons with mental illness may, on that account, pose to themselves or others; or

(d) monitor or evaluate a person's mental state.

(2) However, this professional intervention does not extend to –

(a) special psychiatric treatment; or

(b) a termination of pregnancy; or

(c) a procedure that could render a person permanently infertile; or

(d) the removal, for transplantation, of human tissue that cannot thereafter be replaced by natural processes of growth or repair; or

(e) general health care.

(3) For the purposes of this Act, "treatment" does not include seclusion, chemical restraint, mechanical restraint or physical restraint.

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15. Mental health service delivery principles

All persons exercising responsibilities under this Act are to have regard to the mental health service delivery principles set out in Schedule 1.

16. Circumstances in which treatment may be given

(1) The following policy governs the treatment of voluntary patients under this Act:

(a) a voluntary patient may be given treatment with informed consent, either as a hospital inpatient or in the community;

(b) a voluntary patient may be given special psychiatric treatment if –

(i) the treatment is authorised by the Tribunal under Part 6; and

(ii) where the treatment is psychosurgery or a treatment that requires informed consent under that Part, informed consent has been given for the treatment;

(c) a voluntary patient can never be given special psychiatric treatment except as provided by paragraph (b)

(2) The following policy governs the treatment of involuntary patients under this Act who are not forensic patients or involuntary patients to whom section 66 of the Act applies:

(a) an involuntary patient may be given treatment –

(i) with informed consent; or

(ii) if the treatment is authorised by a treatment order; or

(iii) if the treatment is urgent circumstances treatment, the treatment is authorised under section 55of the Act;

(b) an involuntary patient may be given special psychiatric treatment if –

(i) the special psychiatric treatment is authorised by the Tribunal under Part 6 of the Act; and

(ii) where the treatment is psychosurgery or a treatment that requires informed consent under that Part, informed consent has been given for the treatment;

(c) an involuntary patient can never be given special psychiatric treatment except as provided by paragraph (b)

(3) The following policy governs the treatment under this Act of forensic patients or involuntary patients to whom section 66 of the Act applies:

(a) a forensic patient, or an involuntary patient to whom section 66 of the Act applies, may be given treatment –

(i) with informed consent; or

(ii) if the treatment is authorised by the Tribunal (or a member of the Tribunal) under Division 2 of Part 5 of the Act; or

(iii) if the patient is also an involuntary patient, if the treatment is authorised by a treatment order; or

(iv) if the treatment is urgent circumstances treatment, if the treatment is authorised under section 87 of the Act;

(b) a forensic patient, or an involuntary patient to whom section 66 of the Act applies, may be given special psychiatric treatment if –

(i) the special psychiatric treatment is authorised by the Tribunal under Part 6 of the Act; and

(ii) if the treatment is psychosurgery or a treatment that requires informed consent under that Part, informed consent has been given for the treatment;

(c) a forensic patient, or an involuntary patient to whom section 66 of the Act applies, can never be given special psychiatric treatment except as provided by paragraph (b).

55. Urgent circumstances treatment

(1) An involuntary patient may be given treatment (urgent circumstances treatment) without informed consent or Tribunal authorisation if an approved medical practitioner authorises the treatment as being urgently needed in the patient's best interests.

(2) An approved medical practitioner may, under subsection (1), authorise treatment as being urgently needed in the patient's best interests only if the approved medical practitioner 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 Tribunal (or by a member thereof on an interim basis).

(3) An approved medical practitioner may give the authorisation if, and only if, he or she has concluded from an examination that –

(a) the patient has a mental illness that is generally in need of treatment; and

(b) the urgent circumstances treatment is necessary for –

(i) the patient's health or safety; or

(ii) the safety of other persons; and

(c) the urgent circumstances treatment is likely to be effective and appropriate in terms of the outcomes referred to in section 6(1) of the Act; and

(d) achieving the necessary treatment outcome would be compromised by waiting for the urgent circumstances treatment to be authorised by the Tribunal (or by a member thereof on an interim basis).

(4) The advice under subsection (3) may be given by any means of communication the approved medical practitioner considers appropriate in the circumstances but, if it is given orally, the approved medical practitioner is to confirm it in writing by means of a CCP approved form.

(5) If the authorisation is given, the approved medical practitioner has the following obligations:

(a) to ensure that the patient is advised of the authorisation as soon as possible after it is given;;

(ab) to give a copy of the authorisation to the CCP and the Tribunal;

(ac) to give a copy of the authorisation to the patient (together with a statement of rights in a CCP approved form); and

(b) to place a copy of the authorisation on the patient's clinical record.

(6) If the authorisation is given, the patient may be given the urgent circumstances treatment until whichever of the following first occurs:

(a) the treatment is completed;

(b) an approved medical practitioner, for any reason he or she considers sufficient, stops the treatment;

(c) the 96-hour period immediately following the giving of the authorisation expires;

(ca) the assessment order, treatment order or interim treatment order ceases or is discharged;

(d) the authorisation is set aside by the Tribunal.

Schedule 1

1. 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.