Annual Report 2013-2014

Chief Civil Psychiatrist
Chief Forensic Psychiatrist

Mental Health, Alcohol and Drug Directorate
Department of Health and Human Services

Tasmanian Government

Contents

1. Introduction

I am pleased to provide this first Annual Report on the Chief Civil Psychiatrist and Chief Forensic Psychiatrist's activities during the 2013-2014 Financial Year to the Minister as is required by section 150 of the *Mental Health Act 2013*

In this first report, I have reported on the statutory requirements of the Act and, in addition, have made some observations and presented data regarding the mental health system as a whole in Tasmania.

The *Mental Health Act 2013* (the Act) commenced operation across Tasmania at 12:01am on 17 February, 2014.

The Act, the result of many years of consultation, discussion and planning, brings to Tasmania a relatively new and significant advance in the legislative framework for the treatment of those experiencing mental illness. It represents a major reform in the legal framework for the care and treatment of people with mental illness. Tasmania is the first Australian jurisdiction to enact mental health legislation that introduces decision making capacity as a threshold measure that must be considered before a person may be involuntarily assessed or treated. It has, as its foundations, Tasmania's commitment to human rights and to the recovery model of mental health care.

The Act establishes what is effectively a substitute decision making framework for those who because of their mental illness lack decision making capacity, and cannot make their own assessment and treatment decisions, but who need treatment to prevent harm to their own health or safety or the safety of others. At the same time, it recognises that people who have the capacity to make their own decisions have the right to do so. Decision making capacity becomes the key test for when the *Mental Health Act 2013* may apply. In this manner, the freedom of people to make their own decisions when capable of doing so is preserved.

The Act also enables care and treatment to be given in a timely and appropriate manner, thus ensuring those who are not able to make their own decisions because of mental illness regain decision making ability at the earliest opportunity.

I am pleased to present this first Annual Report of the Chief Civil Psychiatrist and Chief Forensic Psychiatrist to the Minister.

Clinical Associate Professor Leonard Lambeth

Chief Civil Psychiatrist | Chief Forensic Psychiatrist

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Mental Health, Alcohol and Drug Directorate

2. Objectives

The objectives of this report are to:

- Provide to the Minister information about the Chief Civil Psychiatrist and Chief Forensic Psychiatrist's activities under the Act during the 2013-2014 Financial Year.
- Contribute to the improvement of standards of care and treatment for people with a mental illness.
- Inform mental health service users, families, carers, service providers and members of the public about the roles, function and activities of the Chief Psychiatrists.

3. National Context

Mental health policy, planning and service delivery in Tasmania has been shaped and aligned to a range of frameworks and instruments including but not limited to the *4th National Mental Health Plan,* the *National Mental Health Policy (revised 2008),* the *National Standards for Mental Health Services 2010, National Safety Priorities in Mental Health: a national plan for reducing harm 2005,* the *National Mental Health Consumer and Carer Forum,* the *COAG National Action Plan on Mental Health 2006-2011,* the *National Framework for Recovery-oriented Mental Health Services 2013* and the *Mental Health Statement of Rights 2012* which seeks to ensure that consumers, carers, support people, service providers and the community are aware of relevant rights and responsibilities and can be confident in exercising them.

The National Mental Health Reform agenda, commenced in 2012, has also seen the roll out of a range of initiatives aimed at improving mental health service delivery. This includes the *National Partnership Agreement on Mental Health*, Partners In Recovery (PIR) care co-ordination initiative, early intervention psychosis services for young people, establishment of a new national mental health consumer organisation, establishment of the National Mental Health Commission (the Commission) and the National Seclusion and Restraint Project led by the Commission.

4. State Context

Mental health policy, planning and service delivery in Tasmania has been shaped and aligned to be consistent with the national context as outlined above and relevant state policy and planning frameworks including but not limited to Tasmania's Mental Health Promotion, Prevention and Early Intervention Framework*, Building the Foundations for Mental Health and Wellbeing* (2009), *Tasmania's Suicide Prevention Strategy 2009-2014*, the new *Mental Health Act 2013* and international instruments such as the United Nations Convention on the Rights of Persons with Disabilities.

The establishment of Tasmanian Health Organisations (THOs) has also heralded a new framework for the delivery of public health care in Tasmania, including mental health care, with the Department of Health and Human Services (DHHS) becoming a purchaser of services and the THOs the providers.

Most recently, in July 2014 the Tasmanian Government announced further reform with the move from three THOs to the establishment of one Tasmanian Health Service by 1 July 2015.

5. Role and Function of the Chief Psychiatrist

The roles of Chief Civil Psychiatrist and Chief Forensic Psychiatrist as provided for under the Act, are both undertaken by the incumbent to the State Service role of Chief Psychiatrist. The role of Chief Psychiatrist sits within the Mental Health, Alcohol and Drug Directorate, as part of the Department of Health and Human Services, and is responsible for providing high level specialist advice about mental health policy and clinical practice to the Minister, across the Department, to Tasmanian Health Organisations and to other operating units as appropriate.

Broadly speaking, the functions of the Chief Psychiatrist fall into the following domains:

i. Legislative and policy
ii. Strategic quality improvement
iii. Reform
iv. Information and clinical performance

The Chief Psychiatrist was appointed as Chief Forensic Psychiatrist under the *Mental Health Act 1996* in August 2013 and became Chief Forensic Psychiatrist under the Act by virtue of section 6 of the *Mental Health (Transitional and Consequential Provisions) Act 2013*, on 17 February 2014.

The Chief Psychiatrist was appointed as Chief Civil Psychiatrist as provided for under the Act by the Governor with effect from the Act's commencement on 17 February 2014.

The Chief Psychiatrists are responsible under and to the Minister for ensuring that the objects of the Act are met in respect of relevant patients and for the running of approved facilities.

To do this, the Chief Psychiatrists undertake a range of functions including approving forms for use under relevant provisions of the Act, issuing Standing Orders and Clinical Guidelines under sections 151 and 152 of the Act and intervening directly with regard to the assessment, treatment and care of any patient with respect to prescribed matters under section 147 of the Act.

The Chief Psychiatrists have a particular role regarding seclusion, restraint, use of force, leave, visiting, correspondence and telephone rights and assessment and treatment generally, and may issue consequential directions for the future assessment, treatment and care of patients.

The Chief Psychiatrists have an additional statutory role concerning the transfer of patients to secure institutions or approved facilities and the appointment of people to particular statutory roles under the Act.

6. Implementation of the *Mental Health Act 2013*

Prior to the commencement of the Act in February 2014, extensive training materials in the procedural and operational aspects of the Act were developed by the Chief Psychiatrist with assistance from a Mental Health Act project team located within the Mental Health, Alcohol and Drug Directorate.

Training was delivered via face-to-face sessions and online with additional support provided to clinical educators and trainers. Training packages were developed for a wide variety of people including those occupying statutory roles and clinicians in the private and public sectors.

The Chief Psychiatrist has an ongoing commitment to training, and training packages are constantly being revised and updated in order to ensure that patients are provided with clinical care that is of a high standard and fully recognises and adheres to the principles of human rights, least restrictive care and recovery for all.

As is to be expected with any new and ground-breaking piece of legislation, there have been some challenges implementing various operational aspects of the Act. These have generally been of a minor nature and have been substantially overcome with revision of relevant forms, additional training and open, transparent discussion of systemic issues as they arise. The co-operation of all clinicians, Tasmania Police, Ambulance Tasmania, the Mental Health Tribunal, Mental Health Official Visitors, community sector organisations and all stakeholder groups has been invaluable in this regard.

Ongoing work to streamline various aspects of the Act, particularly with respect to decision making capacity, time lines, hearings and resourcing, both in terms of administrative and clinical support continue to be discussed and possible solutions developed. Finding and maintaining the balance between ensuring procedural fairness and at the same time giving adequate clinical time to meet the needs of patients is a continuous aim.

7. Statutory Roles

The following sections provide information about the activity reported to the Chief Civil and Chief Forensic Psychiatrist as required under the *Mental Health Act 2013*. Given the Act has only been operating for a short period of time it does not seek to draw any substantive conclusions from the information reported.

Chief Civil Psychiatrist

The data provided to the Chief Civil Psychiatrist regarding the detention and treatment of patients who are mentally ill and lacking decision making capacity, reflects the Act's operation for a limited period of time and indicates compliance with the fundamental provisions of the Act.

i) Assessment Orders

Applications for Assessment Orders are made pursuant to section 22 of the *Mental Health Act 2013* and may be made to a medical practitioner by:

a. Another medical practitioner
b. A nurse
c. A Mental Health Officer (MHO)
d. A police officer
e. A guardian, parent or support person of the prospective patient
f. An ambulance officer
g. A person prescribed by the regulations

The applicant must be satisfied from personal knowledge of the prospective patient that they have or might have a mental illness and that a reasonable attempt to have the patient assessed with informed consent has failed or that it would be futile or inappropriate to make such an attempt.

Assessment Orders may be made by a medical practitioner (other than the medical practitioner who applied for the Order). The medical practitioner must have examined the person in the 72 hour period immediately before or after receiving the application and be satisfied from the examination that the person needs to be assessed against the assessment criteria. The medical practitioner must also be satisfied that a reasonable attempt to have the patient assessed with informed consent has failed or that it would be futile or inappropriate to make such an attempt.

An Assessment Order may require the patient's detention in an approved hospital. It does not authorise treatment which may only be given under the authority of the Mental Health Tribunal or if authorised as Urgent Circumstances Treatment under section 55 of the Act.

Table 1: ***Applications for Assessment Orders – 17 February 2014 to 30 June 2014***

	Female		Male		Total		Total
Area	**Child**	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Persons**
Interstate*	0	0	0	1	0	1	1
North	3	45	0	50	3	95	98
North West	0	18	0	20	0	38	38
South	1	58	1	49	2	107	109
Grand Total	**4**	**121**	**1**	**120**	**5**	**241**	**246**

Table 2: ***Assessment Orders Made – 17 February 2014 to 30 June 2014***

	Female		Male		Total		Total
Area	**Child**	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Persons**
Interstate*	0	2	0	1	0	3	3
North	4	49	1	51	5	100	105
North West	0	33	0	27	0	60	60
South	1	80	1	76	2	156	158
Grand Total	**5**	**164**	**2**	**155**	**7**	**319**	**326**

Applications for Assessment Orders and completed Assessment Orders tend to reflect the gender distribution across the State. The Act defines a child as anyone under the age of 18, and the small number of children subjected to Assessment Orders is reflective of the fact that treatment of children is most often undertaken with the consent of the parent or guardian.

*There are small numbers of applications received and orders made labelled 'interstate'. These apply to people with an interstate home address who become unwell while in Tasmania.

ii) Treatment Plans

A treatment plan sets out an outline of the treatment the patient is to receive, and are made under sections 50-54 of the *Mental Health Act 2013*. They may be prepared by any medical practitioner involved in the patient's treatment or care and are required for each involuntary patient. They must be made in consultation with the patient and anyone else the medical practitioner thinks fit in the circumstances. This would frequently be a guardian, parent, carer or support person of the patient.

Table 3: ***Treatment Plans Made – 17 February 2014 to 30 June 2014***

	Female		Male		Total		Total
Area	**Child**	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Persons**
Interstate*	0	2	0	1	0	3	3
North	0	36	0	63	0	99	99
North West	0	22	0	29	0	51	51
South	1	60	0	66	1	126	127
Grand Total	**1**	**120**	**0**	**159**	**1**	**279**	**280**

Patients who have a brief admission (less than 96 hours) are generally treated with urgent circumstances treatment and do not require a formal Treatment Plan to be submitted. The Act defines a child as anyone under the age of 18.

*There are small numbers of applications received and Orders made labelled 'interstate'. These apply to people with an interstate home address who become unwell while in Tasmania.

iii) Urgent Circumstances Treatment

Urgent circumstances treatment is treatment given under section 55 of the Act and is authorised by the Chief Civil Psychiatrist or a delegate as being urgently needed in the patient's best interests. Authorisation may be given on the application of any medical practitioner involved in the patient's treatment and care.

Urgent Circumstances treatment may be given for up to 96 hours. In most cases, it will be superseded by either a Treatment Order or an Interim Treatment Order made by the Mental Health Tribunal.

Table 4: ***Number of completed Urgent Circumstances Treatment notifications received by the Chief Civil Psychiatrist under the Mental Health Act 2013 from 17 February 2014 to 30 June 2014***

	Female		Male		Total		Total
Area	**Child**	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Persons**
Interstate*	0	1	0	0	0	1	1
North	1	22	1	25	2	47	49
North West	0	3	0	6	0	9	9
South	0	17	1	27	1	44	45
Grand Total	**1**	**43**	**2**	**58**	**3**	**101**	**104**

The Act defines a child as anyone under the age of 18.

*There are small numbers of applications received and Orders made labelled 'interstate'. These apply to people with an interstate home address who become unwell while in Tasmania.

iv) Seclusion and Restraint

Seclusion is dealt with under section 56 of the Act while restraint is dealt with under section 57 of the Act. Seclusion or restraint may only be used to facilitate a patient's treatment or to ensure the patient's health or safety or the safety of others.

Seclusion may also be used to maintain order in, and the security of, the relevant approved hospital. Restraint, mechanical, physical or chemical, may also be used to effect the transport of a patient from one facility to another.

Under the Act, "mechanical restraint" is defined as a device that controls a person's freedom of movement. The Act allows an involuntary patient to be mechanically restrained only if the means of restraint employed in the specific case has been approved in advance by the Chief Civil Psychiatrist.

The Chief Civil Psychiatrist approved the use of "Posey" brand restraint cuffs and restraint cuffs which are of a similar style and quality, as means of restraint which may be employed in specific cases of mechanical restraint for involuntary patients with effect from 17 February 2014.

Seclusion and restraint are extremely restrictive interventions, the application of which may cause distress for patients, support people and staff members. They are essentially interventions of last resort and may only be applied when less restrictive interventions have been tried without success or have been excluded as inappropriate or unsuitable in the circumstances. The need to ensure that seclusion or restraint are emergency interventions has been recognised by the United Nations through the Principles for Protection of Persons with Mental Illness and the Improvement of Mental Health Care which provide that:

> *Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others.*

Table 5: *Number of completed Seclusion Authorisation notifications received by the Chief Civil Psychiatrist under the Mental Health Act 2013 from 17 February 2014 to 30 June 2014*

	Female		Male		Total		Total
Area	**Child**	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Persons**
North	0	2	0	17	0	19	19
North West	0	3	0	10	0	13	13
South	0	6	0	29	0	35	35
Grand Total	**0**	**11**	**0**	**56**	**0**	**67**	**67**

The Act requires seclusion of a child to be authorised by the Chief Civil Psychiatrist or delegate. The Act defines a child as anyone under the age of 18.

Analysis of seclusion data shows that males accounted for the most episodes of seclusion across all regions. The median time spent in seclusion was 181minutes, with 14.74 per cent of seclusions occurring within the first 24 hours of admission.

Table 6: ***Number of completed Restraint Authorisation notifications received by the Chief Civil Psychiatrist under the Mental Health Act 2013 from 17 February to 30 June 2014***

	Female		Male		Total		Total
Area	**Child**	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Persons**
North	***0***	***2***	***0***	***7***	***0***	***9***	***9***
Mechanical	0	0	0	0	0	0	0
Physical	0	2	0	7	0	9	9
Chemical	0	0	0	0	0	0	0
North West	***0***	***10***	***1***	***13***	***1***	***23***	***24***
Mechanical	0	2	0	0	0	2	2
Physical	0	8	1	13	1	21	22
Chemical	0	0	0	0	0	0	0
South	***0***	***13***	***0***	***25***	***0***	***38***	***38***
Mechanical	0	0	0	0	0	0	0
Physical	0	13	0	25	0	38	38
Chemical	0	0	0	0	0	0	0
State Total	***0***	***25***	***1***	***45***	***1***	***70***	***71***
Mechanical	0	2	0	0	0	2	2
Physical	0	23	1	45	1	68	69
Chemical	0	0	0	0	0	0	0

The Act requires mechanical restraint, chemical restraint and physical restraint of a child to be authorised by the Chief Civil Psychiatrist or delegate. The Act defines a child as anyone under the age of 18.

The median time for a patient to be physically restrained was five minutes, with the most common reason being to facilitate the patient's treatment and ensure the patient's health or safety and the safety of others. The two episodes of mechanical restraint of 5.5 hours in one case and two hours in the second were deemed necessary in order to facilitate the patients' treatment and ensure the patients' health or safety and the safety of others.

v) Involuntary Patient Transfer Between Hospitals

Transfers of involuntary patients between hospitals are made pursuant to section 59 of the *Mental Health Act 2013*. Such transfers are directed by the Chief Civil Psychiatrist if satisfied that the transfer is necessary for the health or safety of the patient or the safety of others.

Table 7: ***Number of completed Involuntary Patient Transfers Between Hospitals applications received by the Chief Civil Psychiatrist under the Mental Health Act 2013 from 17 February 2014 to 30 June 2014***

	Female		Male		Total		Total
Area	**Child**	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Persons**
North	0	1	0	1	0	2	2
North West	0	2	0	3	0	5	5
South	0	6	0	1	0	7	7
Grand Total	**0**	**9**	**0**	**5**	**0**	**14**	**14**

vi) Failure to comply with Treatment Order

Section 47 of the Act applies if a treating medical practitioner is satisfied on reasonable grounds that a patient subject to a Treatment Order has failed to comply with the Treatment Order (despite reasonable steps being taken to ensure compliance) and such failure has seriously harmed or is likely to seriously harm the patient's health or safety or the safety of others and the harm or likely harm cannot be adequately addressed except by way of an alternative treatment or treatment setting. The medical practitioner may apply to the Tribunal to vary the Treatment Order, seek to have the patient taken under escort and involuntarily admitted to an approved facility or apply to the Chief Civil Psychiatrist to give the patient urgent circumstances treatment.

Table 8: ***Number of completed Failure to Comply with Treatment Order – Admission to Hospital notifications received by the Chief Civil Psychiatrist under the Mental Health Act 2013 from 17 February 2014 to 30 June 2014***

	Female		Male		Total		Total
Area	**Child**	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Persons**
North	0	0	0	2	0	2	2
North West	0	0	0	1	0	1	1
South	0	6	0	1	0	7	7
Grand Total	**0**	**6**	**0**	**4**	**0**	**10**	**10**

Chief Forensic Psychiatrist

The data provided to the Chief Forensic Psychiatrist regarding the detention and treatment of forensic patients who are mentally ill and lacking decision making capacity reflects the operation of the Act over a short period of time and demonstrates compliance with the fundamental provisions of the Act.

i) Urgent Circumstances Treatment

Urgent circumstances treatment is treatment given under section 87 of the Act and which is authorised by the Chief Forensic Psychiatrist or a delegate as being urgently needed in the patient's best interests. Authorisation may be given on the application of any medical practitioner involved in the patient's treatment and care.

Urgent circumstances treatment may be given for up to 96 hours. In most cases, it will be superseded by treatment that is authorised by the Mental Health Tribunal under sections 88 or 91 of the Act.

Table 9: ***Number of completed Urgent Circumstances Treatment notifications received by the Chief Forensic Psychiatrist under the Mental Health Act 2013 from 17 February 2014 to 30 June 2014***

	Female		Male		Total		Total
	Child	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Persons**
	0	0	0	2	0	2	2
Grand Total	**0**	**0**	**0**	**2**	**0**	**2**	**2**

ii) Seclusion and Restraint

Seclusion for forensic patients is dealt with under section 94 of the *Mental Health Act 2013*, with restraint for forensic patients dealt with under section 95 of the Act.

Seclusion may only be used to facilitate a 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 (SMHU) or to facilitate the patient's lawful transfer to or from another facility.

Restraint, whether mechanical or physical, may only be used to facilitate a 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 good order or security of the SMHU or to facilitate the patient's lawful transfer to or from another facility.

Chemical restraint may only be used to facilitate a patient's treatment, to ensure the patient's health or safety or the safety of others, or to facilitate the patient's lawful transfer to or from another facility.

Under the Act, "mechanical restraint" is defined as a device that controls a person's freedom of movement. The Act allows a forensic patient to be mechanically restrained only if the means of restraint employed in the specific case has been approved in advance by the Chief Forensic Psychiatrist. On 14 February 2014, the Chief Forensic Psychiatrist approved the use of Hiatts handcuffs with particular serial numbers as means of mechanical restraint for forensic patients, with effect from 17 February 2014.

Table 10: ***Number of completed Seclusion Authorisation notifications received by the Chief Forensic Psychiatrist under the Mental Health Act 2013 from 17 February 2014 to 30 June 2014***

	Female		Male		Total		Total
	Child	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Persons**
	0	0	0	10	0	10	10
Grand Total	**0**	**0**	**0**	**10**	**0**	**10**	**10**

Table 11: ***Number of completed Restraint Authorisation Notifications Received by the Chief Forensic Psychiatrist under the Mental Health Act 2013 from 17 February 2014 to 30 June 2014***

	Female		Male		Total		Total
	Child	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Persons**
Mechanical	0	0	0	0	0	0	0
Physical	0	0	0	4	0	4	4
Chemical	0	0	0	0	0	0	0
Total	***0***	***0***	***0***	***4***	***0***	***4***	***4***

iii) Leave Of Absence

Under sections 81 – 84 of the Act, the Chief Forensic Psychiatrist or a delegate may grant a forensic patient who is not subject to a restriction order leave of absence in Tasmania. Such leave may be granted for a particular purpose, or for a particular period, or both. Leave is granted subject to such conditions as the Chief Forensic Psychiatrist considers necessary and desirable for the patient's health or safety or for the safety of others. There may be a requirement that the patient be under escort for any portion of the leave or for the whole period of leave.

Table 12: ***Number of completed Leave of Absence notifications received by the Chief Forensic Psychiatrist under the Mental Health Act 2013 from 17 February 2014 to 30 June 2014***

	Female		Male		Total		Total
	Child	**Adult**	**Child**	**Adult**	**Child**	**Adult**	**Persons**
	0	0	0	56	0	56	56
Total	***0***	***0***	***0***	***56***	***0***	***56***	***56***

iv) Forensic Patient Transfer to Hospital

Transfer of forensic patients to a secure institution, an approved hospital or a health service may be made pursuant to section 73 of the *Mental Health Act 2013*. Transfer is directed by the Chief Forensic Psychiatrist or delegate and would generally be for the purposes of receiving specialised care in that facility.

Table 13: *Number of completed Forensic Patient Transfer to Hospital notifications received by the Chief Forensic Psychiatrist under the Mental Health Act 2013 from 17 February 2014 to 30 June 2014*

NIL notifications received.

v) Cancellation or Suspension of Visit

Under section 98 (4) of the *Mental Health Act 2013*, the Chief Forensic Psychiatrist may cancel or suspend for a time any individual's privileged visitor, privileged caller, or privileged correspondent status if satisfied on reasonable grounds that the individual has engaged in behaviour that is incompatible with the management, good order or security of a SMHU.

Table 14: *Number of completed Cancellation or Suspension of Visits by the Chief Forensic Psychiatrist under the Mental Health Act 2013 from 17 February 2014 to 30 June 2014*

NIL cancellations or suspensions.

vi) Involuntary Patient Transfer to Secure Mental Health Unit

Under section 63 of the *Mental Health Act 2013*, an involuntary patient may be admitted to a SMHU if the admission is authorised by the Chief Forensic Psychiatrist or delegate upon request by the Chief Civil Psychiatrist or delegate.

Authorisation is given only if, amongst other criteria, the patient is being detained in an approved hospital, is not a prisoner or youth detainee, is a danger to self or others and the SMHU is the only appropriate place where the patient can be safely detained.

A child (defined in the Act as a person under 18 years) may only be admitted to a SMHU if the Chief Forensic Psychiatrist is also satisfied that the patient can be detained separately from adults and that the probable benefits of accommodating the patient in a SMHU outweigh the probable risks.

Table 15: *Number of completed Involuntary Patient Transfers to Secure Mental Health Unit authorised by the Chief Forensic Psychiatrist or delegate under the Mental Health Act 2013 from 17 February 2014 to 30 June 2014*

	Female		Male		Total		Total
	Child	Adult	Child	Adult	Child	Adult	Persons
	0	0	0	4	0	4	4
Total	***0***	***0***	***0***	***4***	***0***	***4***	***4***

In accordance with section 63 of the Act, involuntary patients are only transferred to a secure mental health unit in situations where the danger that the patient poses to self or others is or has become so serious as to make the patient's continued detention in an approved hospital untenable.

vii) Request To Return To Prison

Under section 70 of the *Mental Health Act 2013*, a forensic patient who is a prisoner or youth detainee and whose removal to the SMHU was directed at the patient's own request may request the Chief Forensic Psychiatrist to return him/her to the custody of the relevant authority at any time.

The Chief Forensic Psychiatrist is to have the patient examined by an approved medical practitioner before either agreeing to the request or refusing the request having regard to the results of the examination and whether the reasons for the patient's admission are still valid, as well as such other matters considered to be relevant.

Table 16: ***Number of completed Requests to Return to Prison received by the Chief Forensic Psychiatrist under the Mental Health Act 2013 from 17 February 2014 to 30 June 2014***

	Female		Male		Total		Total
	Child	Adult	Child	Adult	Child	Adult	Persons
	0	0	0	1	0	1	1
Total	***0***	***0***	***0***	***1***	***0***	***1***	***1***

8. Other Roles and Functions

Interstate Agreements

Under section 202 of the *Mental Health Act 2013* an interstate transfer agreement is an agreement between the Minister and the Minister's counterpart in another state providing for the interstate transfer on humanitarian grounds of eligible patients or any class of eligible patients.

Under section 205 of the *Mental Health Act 2013* an interstate control agreement is an agreement between the Minister and the Minister's counterpart in another state providing for either or both the apprehension, detention and return of patients who have absconded from Tasmania and were found interstate and the apprehension, detention and return of interstate patients who are found at large in Tasmania.

No interstate agreements have been negotiated on behalf of the Minister, since the commencement of the *Mental Health Act 2013* on 17 February 2014.

Amendments and regulations

Since the Act has commenced, no amendments or regulations have been promulgated.

Approved Medical Practitioners and Nurses

Pursuant to section 138 of the *Mental Health Act 2013*, a Chief Psychiatrist, by instrument in writing, may approve individual people (or all members of a class of persons) as Medical Practitioners or as Nurses for provisions of the Act or any other Act where the Chief Psychiatrist may have jurisdiction or responsibilities. Anyone approved as a Medical Practitioner must have qualifications or experience in the diagnosis or treatment people with a mental illness while people approved as Nurses must be registered nurses who are qualified or experienced in the treatment or care of people with mental illness.

There were eight approvals, under section 138 of the Act, of individuals as Medical Practitioners for all of the provisions of the Act within the Chief Civil Psychiatrist and Chief Forensic Psychiatrist's jurisdictions since commencement of the Act and no revocations.

There was one approval under section 138 of the Act, of all members of a class of persons (certain nurses) as Approved Nurses for provisions of sections 56-58 of the Act by the Chief Civil Psychiatrist since commencement of the Act and no revocations.

There was one approval under section 138 of the act, of all members of a class of persons (certain nurses) as Approved Nurses for provisions of sections 92, 94, 95 and 96 of the Act by the Chief Forensic Psychiatrist since commencement of the Act and no revocations.

Mental Health Officers

Pursuant to section 139 of the *Mental Health Act 2013*, a Chief Psychiatrist, by an instrument in writing, may approve individuals (or all members of a class of persons) as Mental Health Officers (MHOs) for provisions of the Act or any other Act where the Chief Psychiatrist may have jurisdiction or responsibilities. Anyone approved must have skills, qualifications or experience relevant to the responsibilities of MHOs under the relevant statutory provisions.

There were five approvals, under section 139 of the Act, of individuals as Mental Health Officers for all of the provisions of the Act within the Chief Civil Psychiatrist and Chief Forensic Psychiatrist's jurisdictions since commencement of the Act and no revocations.

There was one approval under section 139 of the Act, of all members of a class of persons (certain ambulance officers) as Mental Health Officers for provisions of the Act within the Chief Civil Psychiatrist and Chief Forensic Psychiatrist's jurisdictions since commencement of the Act and no revocations.

Memorandum of Understanding

Negotiations on the development of a *Memorandum of Understanding for the Delivery of Services to People with a Mental Illness* commenced between the Department of Health and Human Services, the Tasmanian Health Organisations and the Department of Police and Emergency Services during early 2014.

Standing Orders and Clinical Guidelines

Pursuant to sections 151 and 152 of the *Mental Health Act 2013*, a Chief Psychiatrist may issue clinical guidelines and standing orders to help controlling authorities, medical practitioners, nurses or others regarding the exercise of their responsibilities regarding any clinical or non-clinical procedure or matter under provisions of the Act or any other Act where the Chief Psychiatrist may have jurisdiction or responsibilities.

A full list of Standing Orders and Clinical Guidelines introduced by the Chief Civil Psychiatrist and the Chief Forensic Psychiatrist since the commencement of the Act can be found at Appendix 1.

9. Functions Specific to the Chief Forensic Psychiatrist

The Chief Forensic Psychiatrist has a number of legislated functions under Acts other than the *Mental Health Act 2013*, including the *Criminal Justice (Mental Impairment) Act 1999* the *Sentencing Act 1997*, the *Criminal Code Act 1924*, the *Corrections Act 1997* and the *Youth Justice Act 1997*.

A full list of these functions can be found at Appendix 2.

Court Reports

The Chief Forensic Psychiatrist has provided one court report to the Magistrate's Court at the request of the Director of Public Prosecutions (DPP). This was a report on the ability of a patient to drive a motor vehicle.

10. Patient and Service Reporting

Population Demographics

Tasmania's population is 495 354, with 247 461 (50 per cent) living in the South of Tasmania, 137 561(28 per cent) in the North and 109 147 (22 per cent) in the North West[1].

1185 people have no usual address. Males comprise 49 per cent of the population with females comprising 51per cent[2].

Four percent of the population (19 626) identify as being of Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander origin[3]. The median age of Tasmania's non-indigenous population is 40, with the median age of Tasmania's indigenous population being 22[4].

The burden of disease with respect to mental health is extensive and is costly, both in social and monetary terms to the Tasmanian community.

Mental illness comprises a spectrum of disorders that vary in severity. Mental illness can have damaging effects on the individuals and families concerned, and its influence is far-reaching for society as a whole. Social problems commonly associated with mental illness include poverty, unemployment or reduced productivity and homelessness. Those with mental illness often experience problems such as isolation, discrimination and stigma[5].

Estimates from the 2007 National Survey of Mental Health and Wellbeing suggest that 7.3 million Australians (45 per cent of the population aged 16–85) will experience a common mental disorder (a mood disorder, such as depression; anxiety or a substance use disorder) over their lifetime. Each year, 20 per cent of the population in this age range, or 3 million Australians, are estimated to experience symptoms of a mental disorder.

The Report on the Second Australian National Survey of People Living with Psychotic Illness 2010 estimated that almost 64 000 people in Australia had a psychotic illness and were in contact with public specialised mental health services each year.

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1 Health Indicators Tasmania 2013, Population Health, Department of Health and Human Services
2 Health Indicators Tasmania 2013, Population Health, Department of Health and Human Services
3 Health Indicators Tasmania 2013, Population Health, Department of Health and Human Services
4 Australian Bureau of Statistics – Census 2011
5 Mental Health Services in Brief 2012, Australian Institute of Health and Welfare

Over the 2011-2012 period 15 per cent of the Tasmanian population were reported as having been diagnosed with a mental health or behavioural problem at some time in their life (compared with 13.6 per cent for Australia). Yet despite this, the proportion of Tasmanian adults who reported to have experienced high to very high levels of psychological distress in the four weeks prior to interview (8.9 per cent) was lower than for other jurisdictions and Australia as a whole (10.8 per cent)[6].

The high burden of disease with respect to mental disorders in Australia overall, and specifically in Tasmania, necessitates continued surveillance of the services provided to assist people with mental illness. The Chief Psychiatrists' role in ensuring compliance with legislation affecting those who lack capacity to make their own decisions and in developing standing orders and clinical guidelines which promote appropriate management of mental illness is consistent with this need.

Mental Health Facilities and Services

Tasmania's current health system is geographically based, with three Tasmanian Health Organisations (THOs) covering the North, North West and South of the state.

Mental Health Services (MHS) provides specialist clinical mental health services across the state targeted at the estimated three per cent of the Tasmanian community experiencing a severe mental illness. These services are primarily focussed on secondary and tertiary level care for people with serious mental disorders.

Community mental health services

Delivered over three service streams comprising:

- Child and Adolescent Mental Health Services (CAMHS)
- Adult Community Mental Health Services (ACMHS)
- Older Persons Mental Health Services (OPMHS).

Crisis Assessment Treatment and Triage (CATT) services are delivered through community mental health services, providing a mental health crisis response including assessment and triage.

The Mental Health Services Helpline is a 24 hour, seven days a week statewide telephone triage service.

Inpatient and Extended Treatment Mental Health Services

Acute care inpatient units are located at the three public hospitals and offer 24 hour care and treatment. These facilities include Northside Mental Health Clinic (20 beds located at the Launceston General Hospital), Spencer Clinic (19 beds located at the North West Regional Hospital)and the Department of Psychological Medicine (38 bed unit at the Royal Hobart Hospital).

Specialist extended treatment facilities are located in the south and provide statewide services including Millbrook Rise Centre (27 beds), Roy Fagan Centre (42 beds), Mistral Place (10 beds) and Tolosa Street Units (12 beds).

6 The State of Public Health 2013, Population Health, Department of Health and Human Services, Tasmania

Forensic Mental Health Services (FMHS)
Provide community and inpatient mental health care for people experiencing a mental health disorder, who are involved with or at risk of becoming involved with the criminal justice system.

Services are delivered across three streams:

Inpatient Forensic Mental Health Services
These services are provided at Tasmania's secure mental health unit, the Wilfred Lopes Centre (WLC), which is located near but separate from the Risdon Prison complex. WLC commenced operation in February 2006 and is a purpose built dedicated forensic facility, owned by the Department of Health and Human Services (DHHS), and managed on a statewide basis by the THO-South , and Tasmania's first secure mental health unit.

Patients admitted to WLC generally include those found not guilty by reason of insanity or unfit to plead, people with mental illnesses appearing in or remanded from the courts or sent by the courts for assessment, and prisoners with a mental illness or mental health issue that requires specialist mental health inpatient treatment.

WLC operates as a 23 bed facility, including high dependency and extended care beds.

Community Forensic Mental Health Services
Includes services provided to the Tasmanian Prison Service and the WLC and community case management across the state within the general community.

Court Liaison Services
Assist in the assessment and identification of people before the judiciary who may not be fit to plead and/or require diversion into a mental health setting through the Mental Health Diversion List (MHDL). FMHS works in partnership with the Department of Justice to facilitate the MHDL initiative.

Approved Facilities and Secure Mental Health Units
The Chief Civil Psychiatrist has a general and overall responsibility under and to the Minister, for ensuring that the objects of the Act are met regarding the running of approved facilities other than secure mental health units. The Chief Forensic Psychiatrist has a general and overall responsibility under and to the Minister, for ensuring that the objects of the Act are in relation to the running of secure mental health units.

The Chief Civil Psychiatrist also has a general overall responsibility, under and to the Minister to ensure that the objects of the Act are met in relation to patients other than forensic patients or those who are subject to supervision orders, with the Chief Forensic Psychiatrist being similarly responsible for forensic patients and those subject to supervision orders.

11. Observations on the Tasmanian Mental Health Services System

In this section relevant data and comment is provided on the Mental Health Service system in Tasmania. The aim of this is to indicate areas impacting on the delivery of mental health services across the State, highlighting them for consideration as we move forward.

Community Based Mental Health Services Client Contacts

Table 17: ***Number of Clients and Contacts with Clients in Community Based Mental Health Services – Financial Year 2013-14***

Presented below is data indicating demand across the service systems from both a geographic and specialised service-specific perspective.

Team	Active Clients	Contacts	Contacts per client
Adult Community			
Launceston	1220	16838	13.80
Burnie	530	11372	21.46
Devonport	449	9266	20.64
Clarence and Eastern Districts	681	9704	14.25
Hobart and Southern Districts	799	14807	18.53
Glenorchy and Northern Districts	860	15030	17.48
Consult and Liaison			
North	214	639	2.99
South	75	n/a	
Child and Adolescent			
North	406	8005	19.72
North West	489	6109	12.49
South	893	7811	8.75
Older Persons			
North	125	2249	17.99
North West	298	3392	11.38
South	591	3594	6.08
Statewide Services			
Dementia Behaviour Management Advisory Service	456	1688	3.70
Huntingtons Disease Service	98	1200	12.24

Adult Inpatient Services

Table 18: ***Patient numbers for Bed Based Mental Health Services for the Financial Year 2013-14***

This data indicates the utilisation of acute mental health beds across Tasmania.

Ward	THO	Number of Beds	Beds Occ/Day	Occupancy Rate	Average Length of Stay	Separations
Northside Mental Health Clinic	North	20	16.26	81.30%	12.53	524
Spencer Clinic	North West	19	15.41	81.11%	13.30	421
Dept of Psychiatric Medicine	South	30	24.79	82.63%	11.56	972
Psychiatric Intensive Care Unit	South	8	6.67	83.38%	8.16	118

The average length of stay (ALOS) across all in-patient units is below the national average of 16.4 days. This is reflective of the broader work being done to move the mental health system away from crisis-driven care, towards prevention, early intervention and care in the community, with evidence indicating that the appropriate combination of support in the community facilitates optimum recovery.

This not only benefits the individual, but the broader mental health service system, reducing demand on inpatient services and emergency departments and decreasing hospital re-admission rates and homelessness for people with severe and persistent mental illness. Increasingly, Community Service Organisations are playing an important role in contributing to the recovery process for people living with mental illness.

Table 19: ***Inpatient Separations by Gender for Financial Year 2013-2014***

The Tasmanian population is distributed almost equally between men (51 per cent) and women (49 per cent). Inpatient settings tend to reflect this with a small bias towards men treated in all non-forensic inpatient settings with the exception of Spencer Clinic in the North West.

Ward	Separations	Male	Female
Northside	524	266	258
Spencer Clinic	421	209	212
Dept of Psychiatric Medicine	972	498	474
Psychiatric Intensive Care Unit	118	65	53
Total	**2035**	**1038**	**997**
% of Total		**51.01%**	**48.99%**

Inpatient Services for Children and Youth

Tasmania does not have a dedicated Child and Adolescent Mental Health inpatient unit. In the light of this mental health care to children and young people under the age of 18 is provided in the community wherever possible. Where the clinical situation is such that inpatient care is seen as the most appropriate form of care, the preferred option is to provide mental health care and support on the paediatric wards. There are situations in which the most appropriate form of treatment for young people is for them to be specialled in an adult mental health unit until it becomes clinically appropriate to treat either on a paediatric ward or back into the community.

Table 20: ***Children and Youth Separations from Mental Health Inpatient Wards for Financial Year 2013-2014***

	Northside	Spencer	DOP	PICU
Female				
<18	5	12	3	1
Male				
<18	7	0	6	0
Total <18	12	12	9	1
Total Separations	524	421	972	118
% of Separations <18	2.29%	2.85%	0.93%	0.85%
13 years	1	1	0	0
14 years	0	1	0	0
15 years	2	2	2	1
16 years	2	2	2	0
17 years	7	6	5	0

The small numbers of children and youths admitted to a mental health inpatient ward reflects the efforts of clinicians to ensure that this group of patients are treated in the least restrictive environment possible.

Admission to a mental health ward for this group of young people is only undertaken in situations where the behaviour of the young person is such that there is a high risk of harm to themselves or others if admitted to a non-mental health inpatient ward.

Ongoing assessment and treatment of the young person is continuous, with regular evaluation of the need for detention of the young person in the mental health unit.

Table 21: ***Children and Youth with a Primary Mental Health Diagnosis Admitted to non-Mental Health Inpatient Wards***

Age	LGH Paediatric Ward	NWRH Paediatric Ward	RHH Paediatric Ward	RHH Paediatric Ambulatory (Out-Patient Clinics)	Other	TOTAL
0	0	1	3	0	0	4
2	1	1	0	0	0	2
3	2	0	0	0	0	2
4	1	0	1	1	0	3
5	2	0	0	0	0	2
6	3	0	0	0	0	3
7	5	0	1	0	0	6
9	1	1	1	0	0	3
10	1	0	1	0	0	2
11	2	0	2	0	0	4
12	2	1	3	0	1	7
13	3	1	3	0	1	8
14	9	2	14	2	0	27
15	8	4	17	9	3	41
16	10	0	16	6	4	36
17	2	0	13	10	0	25
18	0	0	1	3	0	4
TOTAL	**52**	**11**	**76**	**31**	**9**	**179**

Wherever possible, and where clinically appropriate, children are admitted to a paediatric unit rather than a designated mental health unit. In such a unit, highly skilled staff are able to ensure a high level of age-appropriate care and treatment.

12. Key Initiatives and Areas of Interest to the Chief Psychiatrist

Electro-Convulsive Therapy

Electroconvulsive therapy (ECT) is not dealt with as a special treatment under the *Mental Health Act 2013*. It is one mode of treatment which may be authorised by the Mental Health Tribunal for involuntary patients. It may also be administered to voluntary patients who possess decision making capacity. ECT, while accepted by mental health clinicians, the learned Colleges of Psychiatrists and a topic of much research, has frequently been viewed by non-professionals as a treatment to be feared. It is reported on in these pages to provide the Minister with relevant background and factual data.

ECT is a therapeutic medical procedure for the treatment of severe psychiatric disorders. It has efficacy in treating clinical depression, mania and psychosis, and is occasionally used to treat other neuropsychiatric conditions. Its primary purpose is to quickly and significantly alleviate psychiatric symptoms. It is a treatment which may be potentially life-saving.

ECT involves the delivery of an electrical current to induce a seizure for therapeutic purposes. It is always delivered by a medical practitioner who is appropriately trained and credentialed. Prior to the treatment, another medical practitioner ensures that the patient is anaesthetized. A muscle relaxant is administered with the anaesthetic so there is minimal physical movement during the seizure.

The patient wakes several minutes after the procedure is completed. Careful evaluation of the patient takes place before, during and after the ECT. Treatments are usually given one to three times per week. The length of a course of ECT is highly variable with the average number of treatments used to treat depression ranging from eight to twelve. Some patients may require treatment with continuation or maintenance ECT because other treatments have not been effective in preventing illness relapse. Maintenance ECT typically ranges from an ECT treatment given every week to every few weeks.

There have been substantial developments which have improved the practice of ECT in recent years and there are several valid treatment approaches. There is no single protocol for administering ECT. The treatment approach needs to be individualised to the patient, the disorder and the response to ECT. The practice of ECT is supported by active research aimed at improving efficacy and minimising side effects.

The selection of patients for ECT is conducted by a specialist Psychiatrist with appropriate training and expertise in ECT. Voluntary patients must be able to give informed consent to ECT and involuntary patients will require authorisation for ECT from the Mental Health Tribunal.

Strategic Service Development

There are a number of initiatives which, while not directly related to the operation of the Act, are system level and whole of service issues, warrant the consideration of the Chief Psychiatrist as the senior mental health clinician in Tasmania.

Consumer and carer participation

Consumer and carer participation in the development of recovery-oriented services is paramount as recovery involves partnership between mental health consumers, their carers and families, and health service providers. Recovery seeks to empower consumers in taking control of their lives and therefore calls for a different relationship with the clinician or treatment provider than traditional treatment services which embrace the clinician or provider as the 'expert'[7].

To ensure that we continue to deliver the best mental health care and to support individual journeys of recovery, we need to work directly with consumers, their carers and family, in a positive and genuine spirit of partnership, to ensure that a consumer's individual and family needs are met. The evolution of consumer and carer participation in Tasmania continues with far greater involvement today in the evaluation and design of the mental health service system than ever before.

The Rethink Mental Health Project

A key election commitment and priority for the new government is the development of a long term plan for mental health. The Plan will guide investment in mental health, to develop an integrated system that provides support in the right place, at the right time and with clear signposts about where and how to get help.

[7] Building the Foundations for Mental Health and Wellbeing: A Strategic Framework and Action Plan for Implementing Promotion, Prevention and Early Intervention (PPEI) Approaches in Tasmania, June 2009, Department of Health and Human Services, Tasmania

A key component of the long term plan is the Rethink Mental Health Project. This is an important project aimed at shaping the future of Mental Health Service delivery in Tasmania. It is aimed at achieving better outcomes for consumers, their families and carers from existing mental health expenditure and focussing resources onto frontline services and support.

Broadly the Rethink Project will map existing services and identify service limitations, gaps and barriers for consumers, families and carers, analyse the full range of public, private, federal, state and community sector delivered mental health services and make recommendations for system reform and strategic investment into services, workforce and capital infrastructure.

The Chief Psychiatrist is a member of the Rethink Mental Health Project Steering Committee.

Suicide Prevention

A major concern is the prevalence of suicide in Tasmania, and the risk factors that may lead to suicide. This is an issue for the whole of government and the community, and merits a comprehensive approach.

The Chief Psychiatrist is working with the Mental Health, Alcohol and Drug Directorate in leading state government funded suicide prevention policy, planning, purchasing and monitoring in Tasmania; and is a member of the Tasmanian Suicide Prevention Committee, which provides high level strategic advice and leadership in suicide prevention activities in Tasmania, with a particular focus on implementation of Tasmania's Suicide Prevention Strategy.

The Chief Psychiatrist has an important role in providing to the Directorate advice regarding the evidence for suicide prevention strategies and in the implementation of the Government's suicide prevention election commitments as follows:

- Assisting communities with the implementation of Community Action Plans to prevent suicide.
- Establishing early intervention referral pathways, especially following suicide attempt or self-harm.
- Delivering suicide prevention awareness training to people in key occupations to recognise and respond to the signs.
- Ensuring Tasmanian researchers can access information needed to allow in-depth analysis of Tasmanian suicides, to better target prevention strategies.
- Developing a targeted Youth Suicide prevention Strategy (YSPS) for Tasmania in partnership with the Youth Network of Tasmania (YNOT).
- Undertaking analysis of suicide 'hotspots' to mitigate risks if places are known for repeat suicides.

Physical Health of Patients with Chronic Mental Illness

Another area of concern is the physical health of patients with chronic mental illness. It is estimated that patients with chronic mental illness have a life expectancy as much as 25 years less than those in the general public[8]. Many factors contribute to this, including the side effects of medication to treat serious mental illness, the development of metabolic syndrome, cardiovascular disease, hypertension, respiratory disease and cancers. Smoking, alcohol and drug use, poor dietary habits and a sedentary lifestyle also play a major part.

[8] Improving the Physical Health of People with Severe Mental Illness, June 2012, Department of Health, Victoria

The development of good physical assessment and monitoring procedures will be essential to addressing the physical health needs of patients. Additionally, we will need to ensure that mental health services are integrated in the most efficient manner possible with all relevant services, particularly other medical services such as General Practitioners and alcohol and drug services.

The Chief Psychiatrist is currently developing a Clinical Practice Guideline outlining an approach to management of the physical health of patients with mental illness to support clinical mental health services to further develop this area of practice.

Safety and Quality

Every Tasmanian with mental health needs should be able to access high quality, safe mental health services that uphold the rights and responsibilities of the consumer, their carers and their family.

The National Standards for Mental Health Services (the Standards) were first introduced in 1996 to assist in the development and implementation of appropriate practices and guide continuous quality improvement in mental health services. The Standards have been regarded as a positive in the mental health service sector and have been integral in shaping how services responded to the needs and expectations of consumers and carers.

The Standards were revised in 2010 with Standard 2: Safety, stating: The activities and environment of the MHS are safe for consumers, carers, families, visitors, staff and its community.

Quality improvement and innovation are action areas under the Fourth National Mental Health Plan 2009 – 2014. The recent National Mental Health Report 2013 outlined progress against a range of actions including the development of a national mental health research strategy to drive collaboration and inform the research agenda.

Developing and maintaining a safe and high quality mental health care system is a core function of all mental health care staff. It requires strong leadership, team work and a shared commitment to fostering a culture of service improvement to achieve the best outcomes for mental health consumers. Safeguarding this system requires a commitment to high standards of care and ongoing accountability; to new and emerging evidence and innovation in care; robust clinical governance; and the integration of the views of mental health consumers, their family and carers through strengthening consumer and carer participation. It also requires a commitment to safety and quality in non-clinical settings and within the broader community.

One area of the mental health care system that has been in focus recently is seclusion and restraint. Australian public mental health services have been progressing initiatives to reduce the use of seclusion and restraint in acute settings in line with the National safety priorities in mental health: a national plan for reducing harm, endorsed by Australian Health Ministers in October 2005. This is an issue that is gaining collective national momentum through the National Reducing Seclusion and Restraint project underway through the National Mental Health Commission in which Tasmania is involved.

The Chief Psychiatrist represents Tasmania as a member of the Safety and Quality Partnership Standing Committee (SQPSC), a sub-group of the Mental Health Standing Committee (MHSC). The SQPSC provides expert technical advice and recommendations on the development of national policy and strategic directions for safety and quality in mental health taking into consideration the National Mental Health Strategy, the current Fourth National Mental Health Plan and mainstream health initiatives. The SQPSC may respond, through the provision of advice to the MHSC, on

emerging issues of concern and related safety and quality issues. Issues of concern to the SQPSC include the implementation of National Practice Standards, the mental health workforce, reducing adverse medication events in mental health services, reducing the use of seclusion and restraint in mental health services, reducing suicide and deliberate self-harm in mental health services, ensuring that mental health services aim at a recovery oriented culture of care, the safe transport of people experiencing mental health problems, improving the physical health and well-being of people with mental health problems and recognising and responding to deterioration in mental state.

Participation in the work of the SQPSC enables the Chief Psychiatrist to report on the progress of these initiatives from the Tasmanian perspective and to ensure, through the Mental Health, Alcohol and Drug Directorate, that they become a focus of attention for the delivery of mental health services within the THOs.

Appendix 1: A List of Standing Orders and Clinical Guidelines Introduced by the Chief Civil Psychiatrist (CCP) and Chief Forensic Psychiatrist (CFP) since the introduction of the *Mental Health Act 2013*

Since the introduction of the Act, the Chief Civil Psychiatrist (CCP) has issued the following Standing Orders:

- CCP Standing Order 8 – Urgent Circumstances Treatment
- CCP Standing Order 9 – Seclusion
- CCP Standing Order 10 – Chemical Restraint
- CCP Standing Order 10A – Mechanical and Physical Restraint
- CCP Standing Order 19 – Involuntary Patient Admission to Secure Mental Health Unit

Since the introduction of the Act, the Chief Forensic Psychiatrist (CFP) has issued the following Standing Orders:

- CFP Standing Order 8 - Urgent Circumstances Treatment
- CFP Standing Order 9 – Seclusion
- CFP Standing Order 10 – Chemical Restraint
- CFP Standing Order 10A – Mechanical and Physical Restraint
- CFP Standing Order 15 – Visitor Identification
- CFP Standing Order 16 – Entry Screen and Search
- CFP Standing Order 17 – Unauthorised Items
- CFP Standing Order 19 – Involuntary Patient Admission to Secure Mental Health Unit
- CFP Standing Order 21 – Use of Force

Since the introduction of the Act, the Chief Civil Psychiatrist has issued the following Clinical Guidelines:

- CCP Clinical Guideline 1 – Meaning of Mental Illness
- CCP Clinical Guideline 2 – Capacity
- CCP Clinical Guideline 3 – Representative and Support Persons
- CCP Clinical Guideline 8 – Urgent Circumstances Treatment
- CCP Clinical Guideline 9 – Seclusion
- CCP Clinical Guideline 10 – Chemical Restraint
- CCP Clinical Guideline 10A – Mechanical and Physical Restraint

Since the introduction of the Act, the Chief Forensic Psychiatrist has issued the following Clinical Guidelines:

- CFP Clinical Guideline 2 – Capacity
- CFP Clinical Guideline 3 – Representative and Support Persons
- CFP Clinical Guideline 8 – Urgent Circumstances Treatment
- CFP Clinical Guideline 9 – Seclusion
- CFP Clinical Guideline 10 – Chemical Restraint
- CFP Clinical Guideline 10A – Mechanical and Physical Restraint

Appendix 2: A Full List of Functions Undertaken By the Chief Forensic Psychiatrist (CFP) under Acts Other Than the *Mental Health Act 2013*

Under the *Criminal Justice (Mental Impairment) Act 1999*, the Chief Forensic Psychiatrist's functions include:

- Applying to the Supreme Court for discharge of a restriction order under section 26
- Reporting to the Court under section 26
- Notifying the Attorney General of a defendant's subsequent fitness to stand trial under section 29
- Receiving notification that no further proceedings are to be taken against a defendant from the Attorney General under section 29
- Supervising people on supervision orders under section 29A
- Notifying the MHT of a patient's objection to taking medication under section 29A
- Applying to the court for variation or revocation of a supervision order under section 30
- Reporting to the Court under section 30
- Apprehending a person under section 31
- Receiving notification that a person has been apprehended under section 31
- Authorising the admission to an SMHU of a defendant for an additional period or periods under section 31
- Reporting to the Court under section 35
- Reporting to the Court under section 39
- Reporting to the Court under section 39A
- Authorising persons under section 41A

The Chief Forensic Psychiatrist's functions under the *Sentencing Act 1997* are to provide advice to the Court under section 72, report to the Court under section 75, and supervise a person subject to a supervision order under section 77A.

The Chief Forensic Psychiatrist's functions under the *Criminal Code Act 1924* are to report to the Court under section 348 and to apply to the Court for revocation of a restriction order under section 348.

The Chief Forensic Psychiatrist's functions under the *Corrections Act 1997* are to have input to a decision to admit a prisoner to the SMHU under section 36A, to require the Director, Corrective Services, to remove a prisoner or detainee who has been admitted to the SMHU from the SMHU under section 36A, and to supply to Parole Board with a report under section 74.

The Chief Forensic Psychiatrist's functions under the *Youth Justice Act 1997* include:

- Reporting to the Court under section 105
- Reporting to the Court under section 134A
- Having input to the decision to admit a youth detainee to the SMHU under section 134A
- Requiring the Secretary, Youth Justice to remove a youth detainee from the SMHU under section 134A

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