Annual Report 2017-18

Chief Civil Psychiatrist
Chief Forensic Psychiatrist

Mental Health, Alcohol and Drug Directorate
Department of Health

Tasmanian Government

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Department of Health

Tasmanian Government

The Honourable Michael Ferguson
MP Minister for Health

Dear Minister

I am pleased to present, in accordance with section 150 of the *Mental Health Act 2013*, the Chief Civil Psychiatrist and Chief Forensic Psychiatrists' Annual Report for the 2017 – 2018 Financial Year.

Yours Sincerely

Dr Aaron Robert Groves
Chief Civil Psychiatrist and Chief Forensic Psychiatrist

26 September 2018

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Preface

This report provides an outline of the Chief Civil Psychiatrist and Chief Forensic Psychiatrist's activities during the 2017 – 2018 Financial Year. It reports on the statutory functions of the Chief Psychiatrists under the *Mental Health Act 2013* (Tasmania) (the Act) and makes observations and presents data regarding the mental health system as a whole in Tasmania. It also provides an overview of other work that the incumbent to the Chief Civil Psychiatrist and Chief Forensic Psychiatrist roles has undertaken within the broader mental health sector in Tasmania.

This is my first Annual Report following my appointment as Chief Civil Psychiatrist and Chief Forensic Psychiatrist for Tasmania in November 2017. I would like to acknowledge the former Chief Civil Psychiatrist and Chief Forensic Psychiatrist Dr Len Lambeth for his dedication and service to the roles over many years. I would also like to thank Professor Kenneth Kirkby for his commitment to the performance of the Chief Psychiatrists' functions immediately prior to my commencement, and during periods of leave taken since then.

Thanks also go to staff of the Mental Health, Alcohol and Drug Directorate within the Department of Health without whom the Office of Chief Psychiatrist would not function, and to the Legal Orders Coordinators around the State who provide the Tasmanian Health Service with support every day to ensure the Act is complied with. The work of the Chief Psychiatrists has been assisted by close working relationships with the Mental Health Tribunal, Mental Health Official Visitors Scheme, and the Office of the Health Complaints Commission and the Ombudsman and staff in their respective offices. Regular liaison with each of these bodies has enabled matters of shared interest to be explored and, in many cases, resolved.

This year's report provides an account of processes associated with implementing amendments to the Act which commenced on 1 July 2017. Work on implementing the amendments continues with the support of the Mental Health Tribunal and staff from the Mental Health, Alcohol and Drug Directorate and Tasmanian Health Service. In the coming financial year there will be further revisions to Chief Psychiatrist Approved Forms, Standing Orders and Clinical Guidelines and development of a Plain Language Guide to the Act.

In addition, there are a number of other important projects including a review of the Act and collaboration with the Department of Justice on implementation of the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

The Minister for Health is required to complete a review of the operation of the Act by February 2020 (within 6 years of the Act's commencement) with a report on the outcome of the review to be tabled in each House of Parliament. The review process will be led by the Department of Health with input from the Mental Health Tribunal and other key stakeholders. It is expected that an Issues Paper, identifying key aspects of the Act's operation and seeking feedback, will be released for comment in the coming months.

The Australian Government ratified OPCAT on 21 December 2017 and the Protocol came into force on 20 January 2018. The Tasmanian Government has been working with the Commonwealth and other States and Territories to establish a National Preventative Mechanism or system of local bodies with responsibility for monitoring places of detention, including approved hospitals and approved assessment centres, and Tasmania's secure mental health unit the Wilfred Lopes Centre. The Department of Health's input to this process will likely be led by the Chief Psychiatrists and staff of the Mental Health, Alcohol and Drug Directorate.

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

Dr Aaron Robert Groves
Chief Civil Psychiatrist and Chief Forensic Psychiatrist

Chapter 1: Introduction

This Chapter describes the statutory role and functions of the Chief Civil Psychiatrist and Chief Forensic Psychiatrist. It also sets out the additional roles and functions performed by the incumbent to these statutory roles.

Statutory Role and Function of the Chief Civil Psychiatrist and Chief Forensic Psychiatrist

The Chief Civil Psychiatrist and Chief Forensic Psychiatrist are independent statutory offices established under sections 143 and 144 of the Act respectively.

Under section 143 of the Act, the Chief Civil Psychiatrist has general overall responsibility, under and to the Minister for Health, for ensuring that the objects of the Act are met in respect of involuntary patients, voluntary patients and voluntary inpatients, and for the running of approved hospitals and approved assessment centres.

Under section 144 of the Act the Chief Forensic Psychiatrist has general overall responsibility, under and to the Minister for Health, for ensuring that that the objects of the Act are met in respect of forensic patients and involuntary patients admitted to the secure mental health unit, for people who are subject to supervision orders and for the running of secure mental health units.

The Chief Civil Psychiatrist and Chief Forensic Psychiatrist have the functions given to them by the Act and by other Acts and each Chief Psychiatrist has the power to do anything necessary or convenient to be done to perform these functions. This includes:

- Approving forms for use under relevant provisions of the Act
- Issuing Clinical Guidelines and Standing Orders under sections 151 and 152 of the Act
- Intervening directly with regard to the assessment, treatment and care of patients in certain circumstances under section 147 of the Act
- Authorising seclusion and restraint for certain patients under sections 56, 57, 94 and 95 of the Act
- Directing patient transfers between facilities under sections 59, 72 and 73 of the Act
- Authorising the admission of involuntary patients to secure mental health units under section 63 of the Act
- Approving medical practitioners, nurses and Mental Health Officers under sections 138 and 139 of the Act.

The Chief Civil Psychiatrist and Chief Forensic Psychiatrist also have significant oversight and review responsibilities for decisions made by approved medical practitioners, approved nurses and others in respect of involuntary patients, voluntary inpatients and forensic patients. To this end:

- The Chief Civil Psychiatrist is responsible for:
  - Approving statements of rights required to be given to involuntary patients
  - Receiving a range of documentation including copies of records relating to Protective Custody, Assessment Orders, Treatment Orders and other aspects of patient management
  - Ensuring that each involuntary patient has a Treatment Plan and receiving copies of these once made.
- The Chief Forensic Psychiatrist is responsible for:
  - Approving statements of rights required to be given to forensic patients
  - Considering requests from certain forensic patients to return to prison or youth detention
  - Granting certain forensic patients leave of absence in Tasmania.

Each of the Chief Psychiatrists is appointed by the Governor for a term of up to five years. The person or persons appointed must be a psychiatrist with at least five years' experience in practicing psychiatry and the offices may be held in conjunction with State Service employment.

Professor Ken Kirkby was appointed to be Chief Civil Psychiatrist and Chief Forensic Psychiatrist on 27 August 2016. Professor Kirkby was appointed on a temporary basis to fill an unexpected vacancy and pending permanent recruitment to the role.

Dr Aaron Robert Groves was appointed to be Chief Civil Psychiatrist and Chief Forensic Psychiatrist on 20 November 2017 for a term of five years commencing on 23 November 2017.

Additional Roles and Functions of the Chief Psychiatrist

In practice, the offices of Chief Civil Psychiatrist and Chief Forensic Psychiatrist have been held by the person appointed to the State Service position of Chief Psychiatrist. The Chief Psychiatrist is employed by the Department of Health and is responsible for providing high level specialist advice about mental health policy and clinical practice to the Minister, across the Department, to the Tasmanian Health Service and to other operating units as appropriate.

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 and warrant the consideration of the Chief Psychiatrist.

National Context

The Mental Health Principal Committee (MHPC) of the Australian Health Ministers' Advisory Council (AHMAC) is the leading national body responsible for providing advice to Australian Health Ministers on mental health issues and for setting policy, planning and implementing reform in mental health.

In addition, the Safety and Quality Partnership Standing Committee (SQPSC) of the MHPC – which comprises all Chief Psychiatrists - provides expert technical advice and recommendations on the development of national policy and strategic directions for safety and quality in mental health.

In August 2017, in renewing the National Mental Health Strategy, all Health Ministers agreed to the Fifth National Mental Health Plan and Suicide Prevention Plan (the Fifth Plan), and accompanying Implementation Plan. The Fifth Plan identifies eight Priority Areas, while the Implementation Plan identifies who is responsible for which actions, over the next five years.

The Fifth Plan has eight Priority Areas:

- Priority Area 1: Achieving integrated regional planning and service delivery
- Priority Area 2: Suicide Prevention
- Priority Area 3: Coordinating treatment and supports for people with severe and complex mental illness
- Priority Area 4: Improving Aboriginal and Torres Strait Islander mental health and suicide prevention
- Priority Area 5: Improving the physical health of people living with mental illness and reducing early mortality
- Priority Area 6: Reducing stigma and discrimination
- Priority Area 7: Making safety and quality central to mental health service delivery
- Priority Area 8: Ensuring that the enablers of effective system performance and system improvements are in place.

The MHPC and SQPSC are key components of the governance arrangements for the Fifth Plan. Each has a critical role in leading and coordinating the implementation of Action Items associated with each of these Priority Areas.

A full copy of the Fifth Plan and Implementation Plan can be found on the Council of Australian Government's Health Council Website (www.coaghealthcouncil.gov.au/Publications/Reports).

The Chief Psychiatrist is Tasmania's representative on the MHPC and SQPSC. He is also Tasmania's representative on the Restrictive Practices Subcommittee and Reducing Adverse Medication Events in Mental Health Working Party of the SQPSC.

The SQPSC may respond, through the provision of advice to the MHPC, on emerging issues of concern and related safety and quality issues. Issues of concern to the SQPSC include:

- The implementation of National Standards
- Suicide Prevention – here, the SQPSC is focusing on improving the clinical approach through benchmarking and standards
- Physical Health Care – improving the outcomes for people with mental illness
- Adverse Medication Events – examining medication safety and focusing on reducing adverse events
- Restrictive Practice – reducing restrictive/coercive practices and maintaining a focus on reducing seclusion and restraint in mental health facilities
- Trauma Informed Care – this is a strategic direction for policy and practice reform across all mental health services and aims at recognition and acknowledgement of trauma and its prevalence, alongside awareness and sensitivity to its dynamics

- Peer Workforce – consumer and carer peer workers are an integral part of the mental health workforce with the level of consumer and carer workers employed within mental health services being a key indicator for a recovery-oriented system
- National Disability Insurance Scheme Quality and Safeguarding Framework – primary areas of importance to mental health involve supported decision making, National Standards and restrictive practices.

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 Tasmania.

Priority Area 1 of the Fifth Plan is to achieve integrated regional planning and service delivery. This Priority Area is considered a foundational priority of the Plan as it sets the direction for a new way of planning and commissioning mental health services based on the National Mental Health Service Planning Framework.

The MHPC has established an Integrated Regional Planning Working Group and a National Mental Health Service Planning Framework Steering Group to take forward the national implementation of this Priority Area.

The Chief Psychiatrist is Tasmania's representative on the Integrated Regional Planning Working Group and National Mental Health Service Planning Framework Steering Group. Along with other Chief Forensic Psychiatrists around Australia, the Chief Psychiatrist is also a member of the National Mental Health Service Planning Framework Steering Committee Forensic Panel. In this capacity, the Chief Psychiatrist has responsibility for developing key guidance on the forensic elements of the Planning Framework.

Finally, the Chief Psychiatrist represents the Tasmanian Government on the beyondblue Board.

State Context

Rethink Mental Health

The Chief Psychiatrist is Chair of the *Rethink* Mental Health Plan Implementation Steering Committee.

Rethink Mental Health: *Better Mental Health and Wellbeing – A Long-Term Plan for Mental Health in Tasmania 2015-2025* (*Rethink*) delivers on the Government's commitment to developing an integrated mental health system that provides support in the right place, at the right time and with clear signposts about where and how to get help.

Rethink sets a vision for Tasmania to be a community where all people have the best possible mental health and wellbeing. It brings together action to strengthen mental health promotion, prevention and early intervention, action to improve care and support for people with mental illness, their families and carers and sets a path for integrating Tasmania's mental health system.

Rethink includes short, medium and long-term actions to achieve this vision and identifies 10 reform directions:

- Empowering Tasmanians to maximise their mental health and well-being
- A greater emphasis on promotion of positive mental health, prevention of mental health problems and early intervention
- Reducing stigma
- An integrated Tasmanian mental health system
- Shifting the focus from hospital-based care to support in the community
- Getting in early and improving timely access to support (early in life and early in illness)
- Responding to the needs of specific population groups
- Improving quality and safety
- Supporting and developing our workforce
- Monitoring and evaluating our action to improve mental health and well-being.

The Steering Committee is responsible for overseeing implementation of *Rethink* in Tasmania.

Suicide Prevention

On 26 September 2018, the Australian Bureau of Statistics (ABS) released Causes of Death 2017. The report outlines the official National Suicide Statistics. According to the report, the five-year age-standardised suicide rate for Tasmania (2013-2017) was 15.6 per 100,000 people. This figure is above the national suicide rate of 12.6 and is the fourth highest of all jurisdictions. Suicide prevention is a public health issue for the whole of government and the community and merits a comprehensive approach. This approach underpins the Tasmanian Government's suicide prevention policy direction that was launched in 2016.

Tasmania's suicide prevention policy framework is outlined in a suite of three companion documents that when read together outline the Government's approach.

The ***Tasmanian Suicide Prevention Strategy (2016-2020)*** recognises the specific knowledge, services and resources that exist in Tasmania and that we need to work together to reduce suicide, suicidal behaviour and the impact on Tasmanians. The Strategy prioritises approaches for which there is promising evidence and includes new approaches that aligns with reform occurring in Tasmania and nationally. The Strategy outlines action to be taken in five priority areas:

1. Create a responsive, co-ordinated health service system for people experiencing suicidal thoughts and behaviours and build and promote referral pathways to services and programs so people know how and where to get support
2. Empower and support young people, families and communities to respond to suicidal behaviours and the impact of suicidal behaviours
3. Implement public health approaches to reduce suicidal behaviour and increase community literacy about suicide and suicide prevention
4. Ensure effective implementation, monitoring and evaluation of the Strategy
5. Train and support health workers and other gatekeepers to provide effective and compassionate care and support for people experiencing suicidal thoughts and behaviours – *Suicide Prevention Workforce Development and Training Plan for Tasmania (2016-2020).*

The ***Youth Suicide Prevention Plan for Tasmania (2016-2020)*** takes an evidence-based approach to taking action to reduce youth suicide, suicidal behaviour and the impact upon young people in Tasmania. This Plan identifies five priority areas:

1. Start early by focusing on the resilience, mental health and well-being of children, parents and families
2. Empower young people, families and wider community networks to talk about suicide and respond to young people at risk of suicide
3. Build the capacity of schools, and other educational settings to support young people who may be at risk of suicide or impacted by suicide
4. Develop the capacity of the service system to support young people experiencing suicidal thoughts and behaviours
5. Respond in a timely and effective way to the suicide of a young person to minimise the impact on other young people in Tasmania.

The goal of the ***Suicide Prevention Workforce Development and Training Plan for Tasmania (2016-2020)*** is to support priority workforces to provide effective and compassionate care and support to people experiencing suicidal thoughts and behaviours. This Plan prioritises the following groups:

1. Workforces likely to interact with people experiencing a suicidal crisis
2. Health (and other) workers likely to interact with those at risk of suicide and/or needing ongoing management and care
3. Non-health workforces who may interact with people at risk of suicide or those impacted by suicide
4. Families and carers, community groups and workforces interacting with the community and all other workforces.

The Chief Psychiatrist works closely with the Mental Health and Alcohol and Drug Directorate in leading state government funded suicide prevention policy, planning, purchasing and monitoring in Tasmania; and is Chair of the Tasmanian Suicide Prevention Committee, which provides high level strategic advice and leadership in suicide prevention activities in Tasmania. The Chief Psychiatrist also has an important role in providing advice regarding the evidence for suicide prevention strategies and in the implementation of the Tasmanian Government's suicide prevention policy framework.

Restrictive Practices - Seclusion and Restraint

The Chief Psychiatrist is Chair of the Statewide Restrictive Interventions Review Panel.

The Panel meets on a quarterly basis and examines all incidents of restrictive practices that have been reported to the Panel. The intention is to closely examine each episode to identify structural and case-specific problems and to generate discussion with a view to implementing suitable remedies to reduce these practices.

Figure 1: Tasmanian Seclusion Events per 1 000 Bed Days by Inpatient Unit for the Period 2012– 13 to 2017-18

Unit	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Northside	5.18	16.01	9.2	14.3	4.3	5.0
Spencer	8.43	5.87	5.7	4.8	5.6	5.4
Department of Psychiatry	37.12	23.60	15.3	17.8	17.9	9.5
Wilfred Lopes Centre	2.82	4.86	5.8	10.0	7.0	3.0
TOTAL	**19.74**	**15.20**	**10.1**	**13.1**	**10.2**	**6.4**

Figure 2: National Seclusion Events per 1 000 Bed Days by Jurisdiction for the Period 2012 - 13 to 2016 - 17[1]

Jurisdiction	2012-13	2013-14	2014-15	2015-16	2016-17
New South Wales	9.1	7.9	8.2	8.7	6.9
Victoria	10.9	9.2	7.5	8.6	9.3
Queensland	12.7	11.1	11.4	9.4	7.9
Western Australia	6.0	5.2	4.3	4.8	4.8
South Australia	9.1	4.6	5.0	5.0	6.6
Tasmania	19.7	15.2	10.1	13.1	10.2
Australian Capital Territory	0.9	1.1	2.7	1.6	2.8
Northern Territory	16.6	22.3	30.9	23.9	17.0
Australia	**9.8**	**8.2**	**7.9**	**8.1**	**7.4**

[1] Table RP2. Mental Health Services in Australia – Restrictive Practices

Chapter 2: Implementation of the Mental Health Amendment Act 2016

The Act was passed by the Tasmanian Parliament in 2013 and commenced operation in February 2014.

The *Mental Health Amendment Act 2016* was drafted in response to feedback from clinicians and the Mental Health Tribunal about several aspects of the Act's operation, including the assessment and treatment pathway established by the Act. Several drafting anomalies had also been identified and the *Mental Health Amendment Act* provided an opportunity to address these.

The *Mental Health Amendment Act* amended the Act in a number of ways including by:

- Removing the requirement for an application for an Assessment Order
- Providing authority for an approved medical practitioner, rather than a Chief Psychiatrist, to authorise urgent circumstances treatment
- Altering review requirements applying to Treatment Orders to require the Tribunal to review a Treatment Order within 60 and 180 days after the Order is made, rather than within 30 and 90 days, if the Order is still in effect at the relevant time.

The *Mental Health Amendment Act* received Royal Asset on 6 December 2016 and commenced on 1 July 2017.

The Chief Psychiatrist formed an Implementation Working Group comprising representatives from the Office of Chief Psychiatrist and Tasmanian Health Service in December 2016. The Group met regularly throughout 2017 and in the first half of 2018. The Group provided advice and reviewed all forms and other documentation to ensure the documentation's accuracy in light of the amendments. The meetings provided a forum to discuss the practical requirements of the Act as amended and to explore issues as they arose.

Work on implementing the amendments continued through the 2017 – 2018 Financial Year with the support of the Mental Health Tribunal and staff from the Mental Health, Alcohol and Drug Directorate and Tasmanian Health Service. Work planned for the coming financial year includes further revisions to Chief Psychiatrist Approved Forms, Standing Orders and Clinical Guidelines and development of a Plain Language Guide to the Act.

I would like to express my appreciation for the dedication and effort put in by Working Group members, without whom the implementation would not have been achieved.

Chapter 3: Administration of the Mental Health Act 2013

The Chief Civil Psychiatrist and Chief Forensic Psychiatrist each have powers and functions that relate to administration of the *Mental Health Act 2013* (Tasmania) (the Act).

Approved Facilities, Personnel and Forms; Standing Orders and Clinical Guidelines; and Delegations

The Chief Psychiatrists facilitate and make, or have involvement with, a number of approvals and delegations under the Act. Each Chief Psychiatrist also issues Standing Orders and Clinical Guidelines.

Approved Facilities and Personnel

Approved Hospitals, Approved Assessment Centres and Secure Mental Health Units

The Minister for Health may approve premises as:

- Hospitals for the Act
- Assessment centres for the Act, or
- Secure mental health units for the Act.

Unless the approval provides otherwise, an approved hospital is taken to also be an approved assessment centre.

Tasmania has five approved hospitals:

- The Royal Hobart Hospital (RHH)
- The Launceston General Hospital (LGH)
- The North West Regional Hospital – Burnie Campus (NWRH – Burnie)
- The Millbrook Rise Centre (MRC)
- The Roy Fagan Centre (RFC).

Each of the approved hospitals is also an approved assessment centre for the Act.

Tasmania has one secure mental health unit: The Wilfred Lopes Centre (WLC).

The Chief Civil Psychiatrist has a general overall responsibility, under and to the Minister for Health, for ensuring that the objects of the Act are met in respect of the running of approved hospitals and approved assessment centres.

The Chief Forensic Psychiatrist has, in turn, a general overall responsibility, under and to the Minister for Health, for ensuring that the objects of the Act are met in respect of the running of secure mental health units.

Secure Institutions

The Minister for Health may approve an institution, other than an approved hospital, approved assessment centre or secure mental health unit, as a secure institution.

A forensic patient who is transferred to a secure institution is taken to be in the custody of the controlling authority of the secure mental health unit from which he or she was transferred throughout the period of his or her detention in the secure institution. Provisions of the Act regulating the admission and custody of forensic patients apply to forensic patients who are being detained in a secure institution as if the forensic patient were in the secure mental health unit, and in respect of the secure institution as if it were a secure mental health unit.

Tasmania has two secure institutions:

- The Hobart Reception Prison
- The Launceston Reception Prison.

It is occasionally necessary for a forensic patient to leave the Wilfred Lopes Centre on a temporary basis to, for example, attend a medical appointment or court appearance. Approval of the Reception Prisons as secure institutions clarifies that these facilities are places to which the Act applies for the duration of the patient's transfer.

Approved Medical Practitioners and Nurses

The Act provides for approved medical practitioners, and approved nurses.

Approved medical practitioners have a range of powers and functions under the Act including:

- Affirming and discharging Assessment Orders
- Assessing involuntary patients subject to Assessment Orders to confirm whether the patient meets the assessment criteria and to determine if the patient also meets the treatment criteria
- Authorising urgent circumstances treatment
- Applying for and discharging Treatment Orders
- Applying for the renewal or variation of Treatment Orders
- Granting involuntary patients leave of absence from approved hospitals
- Applying for authorisation of treatment for forensic patients
- Examining patients placed in seclusion or under restraint.

Approved nurses have powers relating to seclusion and restraint of involuntary and forensic patients. A Chief Psychiatrist, by instrument in writing, may approve individual people (or all members of a class of people) as medical practitioners or nurses for the Act. The power to do so is set out in section 138 of the Act.

Approval may be for any (or all) provisions of the Act within the relevant Chief Psychiatrist's jurisdiction and for any (or all) provisions of any other Act in respect of which the relevant Chief Psychiatrist has responsibilities.

To be approved as a medical practitioner, or to be a member of a class of people so approved, a person must be a psychiatrist or a medical practitioner who is otherwise qualified or experienced in the diagnosis or treatment of mental illness.

To be approved as a nurse, or to be a member of a class of people to whom the approval relates, a person must be a registered nurse who is qualified or experienced in the treatment or care of people with mental illness.

Approval takes effect on the day it is given or a later day, if specified, and remains in effect for five years unless sooner revoked.

For the period 1 July 2017 to 30 June 2018:

- 93 people were approved as medical practitioners for the Act
- 6 people were approved as nurses for the Act
- No classes of people were approved as either medical practitioners or nurses
- There were no revocations of medical practitioners or nurses previously approved.

Mental Health Officers

The Act also provides for Mental Health Officers. Mental Health Officers have a range of powers and functions under the Act including the power to:

- Take a person into protective custody and escort the person to an approved assessment centre
- Take an involuntary patient under escort to ensure that he or she presents for assessment under an Assessment Order or treatment under a Treatment Order
- Take a patient who is being transferred from one approved hospital to another under escort for the purposes of the transfer
- Conduct a frisk or ordinary search of a patient who has been taken into protective custody or under escort in certain circumstances.

Ambulance officers and medical practitioners who are approved as Mental Health Officers under the Act may also sedate patients who are being transported under the Act in certain circumstances. The power to sedate patients in this manner is set out in section 212 of the Act.

A Chief Psychiatrist, by instrument in writing, may approve individual people (or all members of a class of people) as Mental Health Officers for the Act. The power to do so is set out in section 139 of the Act.

Approval may be for any (or all) provisions of the Act within the relevant Chief Psychiatrist's jurisdiction and for any (or all) provisions of any other Act in respect of which the relevant Chief Psychiatrist has responsibilities.

To be approved as a Mental Health Officer, or to be a member of a class of people to whom the approval relates, a person must have skills, qualifications or experience relevant to the responsibilities of Mental Health Officers under the relevant provisions.

Approval takes effect on the day it is given or a later day, if specified, and remains in effect for five years unless sooner revoked.

Approval of ambulance officers as Mental Health Officers may only be given with consent of the Commissioner of Ambulance Services while approval of police officers as Mental Health Officers may only be given with consent of the Commissioner of Police.

For the period 1 July 2017 to 30 June 2018:

- 39 ambulance officers were approved as Mental Health Officers for the Act
- 38 other people were approved as Mental Health Officers for the Act
- No police officers were approved as Mental Health Officers for the Act
- There were no revocations of ambulance officers or other people previously approved.

Authorised Persons

Under the Act, authorised persons are people who have been approved by the Chief Forensic Psychiatrist or the controlling authority of a secure mental health unit for the purposes of any or all of the provisions of the Act.

Authorised persons have a range of powers and functions under the Act relating to forensic patients. This includes including the power to:

- Transport an involuntary patient who has been admitted to a secure mental health unit from the unit to an approved hospital
- Transport a forensic patient who is being transferred from a secure mental health unit to an approved hospital, secure institution, health service or premises from which a health service is provided
- Apply force to a forensic patient in certain, limited circumstances
- Perform functions relating to visitors to the secure mental health unit including requiring a person seeking entry to the unit to provide proof of identity or status
- Perform functions in relation to telephone calls and mail to and from forensic patients.

The Chief Forensic Psychiatrist or the controlling authority of a secure mental health unit may authorise a person, or a member of a class of people, for the purposes of relevant provisions of the Act under section 109 of the Act.

For the period 1 July 2018 to 30 June 2018:

- No people were authorised under section 109 of the Act
- No classes of people were authorised under section 109 of the Act.

Approved Forms

Each of the Chief Psychiatrists has the power to approve forms for use under provisions of the Act within his or her jurisdiction, or under provisions of other Acts in respect of which he or she may have responsibilities.

In the period 1 July 2017 – 30 June 2018:

- The Chief Civil Psychiatrist approved new forms on 17 occasions
- The Chief Forensic Psychiatrist approved new forms on eight occasions.

A list of forms that have been approved by the Chief Civil Psychiatrist and Chief Forensic Psychiatrist and in place as at 30 June 2018 can be found at Appendix 1.

Standing Orders and Clinical Guidelines

Clinical Guidelines indicate how a provision of the Act or another Act ought to be applied in a practical or forensic setting.

Each of the Chief Psychiatrists may issue Clinical Guidelines to help controlling authorities, medical practitioners, nurses or other people in the exercise of their responsibilities in respect of any treatment, clinical procedure or other clinical matter under provisions of the Act within the relevant Chief Psychiatrist's jurisdiction, or under provisions of other Acts in respect of which the Chief Psychiatrist has responsibilities.

A person exercising responsibilities in respect of a matter for which Clinical Guidelines have been issued is to have regard to those guidelines. While failure by an individual to have regard to Clinical Guidelines is not an offence it may constitute proper grounds for instituting professional or occupational disciplinary action, particularly if the failure leads to unfavourable patient outcomes that might otherwise have been avoided or if there is a history of disregard.

Standing Orders indicate how a provision of the Act or another Act ought to be applied in a practical clinical or forensic setting.

Each of the Chief Psychiatrists may issue Standing Orders to controlling authorities, medical practitioners, nurses or other people regarding the exercise of their responsibilities in respect of any clinical or non-clinical procedure or other matter under provisions of the Act within the relevant Chief Psychiatrist's jurisdiction, or under provisions of other Acts in respect of which the Chief Psychiatrist has responsibilities.

A person exercising responsibilities in respect of a matter for which Standing Orders have been issued must comply with those Standing Orders. While failure by an individual to comply with Standing Orders is not an offence it does constitute proper grounds for instituting professional or occupational disciplinary action against that individual.

The power to issue Clinical Guidelines and Standing Orders is set out in sections 151 and 152 of the Act respectively.

For the period 1 July 2017 – 30 June 2018, one new Standing Order was issued: Chief Forensic Psychiatrist Standing Order 22. Standing Order 22 relates to sections 92 and 93 of the Act and to the Use of Force – Personal Hygiene. The Standing Order was issued to address a specific circumstance and is of limited application. While the Standing Order has been distributed as required by the Act it has not been published.

A list of Standing Orders and Clinical Guidelines introduced by the Chief Civil Psychiatrist and the Chief Forensic Psychiatrist since the Act's commencement in 2014, and in place as at 30 June 2018 can be found at Appendix 2.

Delegations

The Chief Civil Psychiatrist and Chief Forensic Psychiatrist may delegate any of their powers or functions under the Act or any other Act other than the power of delegation, the power to issue, vary or revoke Clinical Guidelines and Standing Orders and powers relating to special psychiatric treatment. The Chief Psychiatrists' power to delegate is set out in section 149 of the Act.

In some cases, powers and functions may only be delegated to another medical practitioner. This includes the power to authorise seclusion or restraint.

For the period 1 July 2017 – 30 June 2018, the Chief Civil Psychiatrist delegated certain of his powers and functions under the Act and the *Sentencing Act 1997* (Tasmania) to:

- The holders of particular offices or positions on four occasions (5 July 2017, 9 February 2018, 9 May 2018 and 10 May 2018)
- People by name on 18 occasions.

For the period 1 July 2017 – 30 June 2018, the Chief Forensic Psychiatrist delegated certain of his powers and functions under the Act, the *Criminal Justice (Mental Impairment) Act 1999* (Tasmania), the *Corrections Act 1997* (Tasmania), the *Youth Justice Act 1997* (Tasmania), the *Criminal Code Act 1924* (Tasmania), the *Justices Act 1959* (Tasmania) and the *Sentencing Act* to:

- The holders of particular offices or positions on two occasions (5 July 2017 and 9 February 2018)
- People by name on 12 occasions.

The Minister for Health, and the controlling authority of an approved facility, may also delegate their powers and functions under the Act. For approved facilities run by or on behalf of the State, the controlling authority is the Secretary, Department of Health.

The Minister may delegate any of his or her responsibilities under the Act other than the power of delegation and the power to approve premises as hospitals, assessment centres or secure mental health units for the Act, and the power to revoke such an approval. The controlling authority may delegate any of the controlling authority's powers under the Act or any other Act other than the power of delegation.

The Minister's power to delegate his powers is set out in section 220 of the Act while the controlling authority's power to delegate is set out in section 221 of the Act.

For the period 1 July 2017 – 30 June 2018, neither the Minister nor the controlling authority delegated any of their powers and functions under the Act.

Chief Psychiatrist Powers and Functions, and Oversight

The Chief Civil Psychiatrist and Chief Forensic Psychiatrist each have a range of powers and functions. These are usually performed in practice by a delegate of the relevant Chief Psychiatrist.

The Chief Psychiatrists have both powers and functions, and an oversight role in respect of seclusion and restraint. This report includes matters relating to seclusion and restraint as matters relating to the Chief Psychiatrists' powers and functions, rather than oversight.

The Chief Psychiatrists' oversight responsibilities are essential for ensuring that the Act is applied correctly. These responsibilities are facilitated through receipt of information relating to decisions made under the Act by approved medical practitioners and others.

Chief Civil Psychiatrist Powers and Functions

Treatment Plans

A treatment plan is a document that outlines the treatment a patient is to receive. They are compulsory for all involuntary patients.

A patient's treatment plan may be prepared by any medical practitioner involved in the patient's treatment or care. In preparing a treatment plan, a medical practitioner is to consult the patient. The practitioner may, after consulting the patient, also consult with others, such as the patient's family, carers or other support people.

A medical practitioner who prepares a treatment plan is required to give a copy of the plan to the patient and the Chief Civil Psychiatrist. A copy of the plan must also be placed on the patient's clinical record.

Figure 3: Treatment Plans by Area for the Period 2014-15 to 2017-18

Area	2014-15	2015-16	2016-17	2017-18
North	247	216	206	122
North West	143	149	189	167
South	396	428	374	374
Interstate	10	9	11	6
Total	**796**	**802**	**780**	**669**
% Children	0.75%	0.50%	1.79%	1.20%

Area	2014-15	2015-16	2016-17	2017-18
% Female (all ages)	42.59%	45.39%	42.56%	43.35%
% Male (all ages)	57.41%	54.61%	57.44%	56.65%

Seclusion and Restraint

An involuntary patient may be placed in seclusion or under physical, mechanical or chemical restraint pursuant to the Act in certain, limited circumstances. The circumstances in which an involuntary patient may be placed in seclusion are set out in section 56 of the Act while the circumstances in which an involuntary patient may be placed under restraint are set out in section 57 of the Act.

An involuntary patient may only be placed in seclusion if the patient is in an approved hospital and:

- The seclusion is authorised as being necessary to facilitate the patient's treatment, to ensure the patient's health or safety or the safety of other persons, or to provide for the management, good order or security of the approved hospital
- The person authorising the seclusion is satisfied that it is a reasonable intervention in the circumstances
- The seclusion lasts for no longer than is authorised
- The seclusion is managed in accordance with Chief Civil Psychiatrist Standing Orders or Clinical Guidelines.

For a child patient (a patient under the age of 18 years), authorisation must come from the Chief Civil Psychiatrist or a delegate. For other patients, authorisation may be given by the Chief Civil Psychiatrist or a delegate, a medical practitioner or an approved nurse.

An involuntary patient may only be placed under restraint if the patient is in an approved hospital or approved assessment centre and:

- The restraint is authorised as being necessary to facilitate the patient's treatment, to ensure the patient's health or safety or the safety of others, or to effect the patient's transfer to another facility, whether in Tasmania or in another State
- The person authorising the restraint is satisfied that it is a reasonable intervention in the circumstances
- The restraint lasts for no longer than is authorised
- In the case of mechanical restraint, the means of restraint employed in the particular case is approved in advance by the Chief Civil Psychiatrist
- The restraint is managed in accordance with Chief Civil Psychiatrist Standing Orders or Clinical Guidelines.

In relation to chemical or mechanical restraint, and the physical restraint of a child (a person under the age of 18 years) authorisation must come from the Chief Civil Psychiatrist or a delegate. For other cases of physical restraint, authorisation may be given by the Chief Civil Psychiatrist or a delegate, a medical practitioner or an approved nurse.

Under the Act:

- Mechanical restraint is defined as a device that controls a person's freedom of movement

- Chemical restraint is defined as medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition
- Physical restraint is defined to mean bodily force that controls a person's freedom of movement.

Seclusion and restraint are restrictive interventions, and their application 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.

A person who authorises seclusion or restraint is required to make a record of the matter and to give a copy of the record to the patient, the Chief Civil Psychiatrist and the Mental Health Tribunal. A copy of the record is also required to be placed on the patient's clinical record.

For the period 1 July 2017 – 30 June 2018, four notifications of a child being secluded were received. Three of these related to the Royal Hobart Hospital and one related to the North West Regional Hospital – Burnie Campus.

The median time spent in seclusion was 91 minutes, with the most common reason being to facilitate the patient's treatment (48.91%), ensure the patient's health or safety (31.39%) and ensure the safety of other persons (16.79%).

Figure 4: Occasions of Seclusion by Hospital for the Period 2014-15 to 2017-18

Hospital	2014-15	2015-16	2016-17	2017-18
LGH	105	77	30	25
NWRH – Burnie	57	20	26	17
RHH	275	181	195	91
MRC	n.a.	19	10	3
RFC	n.a.	0	1	1
Total	**437**	**297**	**262**	**137**
% Female (all ages)	37.30%	50.84%	66.41%	41.61%
% Male (all ages)	62.70%	49.16%	33.59%	58.39%
% Other (all Ages)	0%	0%	0%	0%

NOTE:

1. The figures presented here for seclusion may differ from the National Collection of Seclusion data due to different scope of collection.

2. The total persons may not equal the sum of person by unit as individuals may be secluded in more than one unit.

For the period 1 July 2017 – 30 June 2018, eight notifications of a child being placed under physical restraint were received. Four of these related to the North West Regional Hospital – Burnie Campus, three related to the Royal Hobart Hospital and one related to the Launceston General Hospital.

The median time for a patient to be physically restrained was four minutes, with the most common reason being to facilitate the patient's treatment (57.25%), ensure the safety of others (19.61%) and ensure the patient's health or safety (14.51%).

Figure 5: Occasions of Restraint by Hospital and Type for the Period 2014-15 to 2017-18

Area	2014-15	2015-16	2016-17	2017-18
LGH	**58**	**53**	**90**	**56**
Mechanical	4	5	3	5
Physical	50	48	85	51
Chemical	4		2	
NWRH - Burnie	**57**	**48**	**54**	**76**
Mechanical	2	3	2	8
Physical	55	43	48	65
Chemical		2	4	3
RHH	**143**	**221**	**171**	**118**
Mechanical	2	25	8	4
Physical	139	194	160	111
Chemical	2	2	3	3
MRC	**0**	**20**	**6**	**5**
Mechanical		0		
Physical		20	6	5
Chemical		0		
RFC	**0**	**0**	**3**	**0**
Mechanical				
Physical			3	
Chemical				
State Total	**258**	**342**	**324**	**255**
Mechanical	8	33	13	17
Physical	244	305	302	232
Chemical	6	4	9	6
Mechanical Female	50.00%	27.27%	61.54%	41.18%
Mechanical Male	50.00%	72.73%	38.46%	58.82%
Physical Female	58.20%	58.36%	65.56%	56.03%
Physical Male	41.80%	41.64%	34.44%	43.97%
Chemical Female	50.00%	50.00%	44.44%	33.33%
Chemical Male	50.00%	50.00%	55.56%	66.67%

The Mental Health Tribunal has oversight of instances of seclusion and restraint, including instances of seclusion and restraint authorised by the Chief Civil Psychiatrist.

Transfer of Involuntary Patients between Hospitals

The Chief Civil Psychiatrist or a delegate may direct that an involuntary patient be transferred from one approved hospital to another if satisfied that the transfer is necessary for the patient's health or safety, or for the safety of other people. The circumstances and manner in which an involuntary patient may be transferred are set out in section 59 of the Act.

The Chief Civil Psychiatrist or delegate is required to document the transfer and to give a copy of the transfer direction to the patient, the controlling authority of each hospital, the patient's treating medical practitioner and the Tribunal. A copy of the transfer direction is also required to be placed on the patient's clinical record.

For the period 1 July 2017 – 30 June 2018, no children were transferred.

Figure 6: Involuntary Patient Transfers between Hospitals for the Period 2014-15 to 2017-18

Originating Hospital	Destination Hospital	2014-15	2015-16	2016-17	2017-18
LGH	RHH	13	4	4	1
LGH	NWRH – Burnie	8	1	15	18
NWRH – Burnie	RHH	5	0	5	2
NWRH – Burnie	LGH	10	1	16	9
RHH	LGH	3	0	3	3
RHH	NWRH – Burnie	1	0	5	2
Total Transfers		40	6	48	35

Admission of Involuntary Patients to Secure Mental Health Units

An involuntary patient may be admitted to a secure mental health unit in certain circumstances. These are set out in section 63 of the Act.

An involuntary patient may only be admitted to a secure mental health unit if the admission is authorised by the Chief Forensic Psychiatrist and if:

- The patient is being detained in an approved hospital
- The patient is not a prisoner or youth detainee
- The Chief Civil Psychiatrist has formally asked the Chief Forensic Psychiatrist to give the authorisation, and
- The Chief Forensic Psychiatrist is satisfied that:
    - The patient is, by reason of mental illness, a danger to himself or herself or to others
    - The danger has become so serious as to make the patient's continued detention in the approved hospital untenable
    - In the circumstances, a secure mental health unit is the only appropriate place where the patient can be safely detained, and
    - The particular secure mental health unit has the resources to give the person appropriate treatment and care.

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

The Chief Forensic Psychiatrist is to determine the period for which the patient may be detained in the secure mental health unit and may extend that period, in consultation with the Chief Civil Psychiatrist.

If the Chief Forensic Psychiatrist is satisfied at any time that the patient no longer meets the requirements for admission he may ask the Chief Civil Psychiatrist to arrange for the patient to be transferred back to an approved hospital. The Chief Civil Psychiatrist must accede to such a request.

Figure 7: Transfers of Involuntary Patients to Secure Mental Health Units for the Period 2014-15 to 2017-18

	2014-15	2015-16	2016-17	2017-18
Involuntary patient transfer to SMHU	20	16	6	1
% Female (all ages)	10.00%	37.50%	50.00%	0.00%
% Male (all ages)	90.00%	62.50%	50.00%	100.00%

The Mental Health Tribunal has oversight of the admission, and any extension of the period of admission, of an involuntary patient to a secure mental health unit.

Correction of Orders where Validity Not Affected

An error in a Chief Civil Psychiatrist approved form that does not affect the form's validity may be corrected by the Chief Civil Psychiatrist.

For the period 1 July 2017 – 30 June 2018, the Chief Civil Psychiatrist did not correct any errors in Chief Civil Psychiatrist approved forms.

Functions and Powers under other Acts

The Chief Civil Psychiatrist has functions and powers under the *Criminal Justice (Mental Impairment) Act* and the *Sentencing Act*.

A full list of these functions can be found at Appendix 3.

Chief Civil Psychiatrist Oversight

Protective Custody

A Mental Health Officer or police officer may take a person into protective custody if the Mental Health Officer or police officer reasonably believes that:

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

A Mental Health Officer or police officer who has taken a person into protective custody must escort that person to an approved assessment centre, or ensure that this occurs. The controlling authority of the approved assessment centre must then ensure that the person is examined by a medical practitioner within four hours of the person's arrival. The purpose of the examination is to see if the person needs to be assessed against the assessment criteria or the treatment criteria.

A Mental Health Officer or police officer who has a person in protective custody must release the person from that custody if:

- Informed consent is given to assess or treat the person, or
- An Assessment Order or Treatment Order is made in respect of the person, or
- The Mental Health Officer or police officer reasonably forms the belief that the person no longer meets the criteria for being taken into protective custody, or
- None of these things have occurred within four hours of the person's arrival at an approved assessment centre.

A Mental Health Officer or police officer who takes a person into protective custody or who transfers the person's custody to another officer, and any medical practitioner who examines the person in protective custody, is to make an appropriate record of the matter. A copy of the record is to be given to the person, and to the Chief Civil Psychiatrist. A copy of the medical practitioner's examination is also to be placed on the person's clinical record.

Matters relevant to Protective Custody are set out in sections 17 – 21 and Schedule 2 of the Act.

Figure 8: Number of People taken into Protective Custody by Area for the Period 2014-15 to 2017-18

Area	2014-15	2015-16	2016-17	2017-18
North	92	111	113	126
North West	89	118	175	197
South	171	192	214	211
Interstate	5	4	7	10
Total	**357**	**425**	**509**	**544**
% Children	2.52%	4.24%	6.29%	6.07%
% Female (all ages)	40.62%	46.35%	47.94%	47.79%
%Male (all ages)	59.38%	53.65%	52.06%	52.21%

Assessment Orders – Affirmation and Discharge

A medical practitioner may make an Assessment Order in respect of a person if the medical practitioner has examined the person in the 24 hour period immediately before the Assessment Order is made and is satisfied from that 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 person assessed with informed consent has failed, or that it would be futile or inappropriate to attempt to have the person assessed with informed consent.

The assessment criteria are set out in section 25 as follows:

- The person has, or appears to have, a mental illness that requires or is likely to require treatment for the person's health or safety or the safety of others
- The person cannot be properly assessed with regard to the mental illness or the making of a Treatment Order except under the authority of the Assessment Order, and
- The person does not have decision making capacity.

The meaning of decision-making capacity is set out in section 7 of the Act.

An Assessment Order is 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.

The treatment criteria are set out in section 40 of the Act as follows:

- The person has a mental illness
- Without treatment, the mental illness will, or is likely to, seriously harm the person's health or safety or the safety of others
- The treatment will be appropriate and effective
- The treatment cannot be adequately given except under a Treatment Order, and
- The person does not have decision making capacity.

A patient subject to an Assessment Order must be assessed by an approved medical practitioner other than the medical practitioner who made the Order within 24 hours of the Order taking effect. The approved medical practitioner must immediately either affirm, or discharge, the Order; an approved medical practitioner who affirms an Order may simultaneously extend its operation by a period of up to 72 hours from the time of affirmation.

An approved medical practitioner who affirms or discharges an Assessment Order is to give notice to that effect to the patient, the Chief Civil Psychiatrist and others. He or she is also required to place a copy of the instrument of affirmation, or discharge paper, on the patient's clinical record.

Matters relevant to Assessment Orders are set out in sections 22 – 35 of the Act.

Statistical data is not provided for the affirmation or discharge of Assessment Orders by approved medical practitioners.

Treatment Orders – Admission to Approved Facility

A patient's treating medical practitioner may seek to have an involuntary patient who has failed to comply with a Treatment Order admitted to, and if necessary detained in, an approved hospital. The circumstances in which this may occur are set out in section 47 of the Act.

A patient's treating medical practitioner may only seek to take action under section 47 of the Act if:

- The patient is subject to a Treatment Order
- Reasonable steps have been taken to obtain the patient's compliance with the Order, and
- The treating medical practitioner is satisfied on reasonable grounds that despite those reasonable steps, the patient has failed to comply with the Treatment Order and that the failure in compliance has seriously harmed, or is likely to seriously harm, the patient's health or safety or the safety of other persons, in circumstances where the harm or likely harm cannot be adequately addressed except by way of a treatment or treatment setting that is inconsistent with the treatment or treatment setting specified in the Treatment Order.

Other action available to a patient's treating medical practitioner under section 47 includes:

- Applying to the Mental Health Tribunal to have the Treatment Order varied, or
- Authorising urgent circumstances treatment or seeking authorisation to give urgent circumstances treatment if the treating medical practitioner is not also an approved medical practitioner.

If a patient is admitted to an approved facility under section 47 of the Act, the controlling authority of the approved facility is to notify the Chief Civil Psychiatrist (and the Tribunal) of the patient's admission.

Admission in the event of failure to comply is generally to one of Tasmania's major hospitals – the Royal Hobart Hospital, the Launceston General Hospital and the North West Regional Hospital – Burnie Campus.

Figure 9: Failures to Comply with Treatment Orders – Action Taken under section 47 of the Act by Hospital for the Period 2014-15 to 2017-18

Hospital	2014-15	2015-16	2016-17	2017-18
LGH	9	6	11	8
NWRH – Burnie	10	1	6	11
RHH	19	5	13	28
Total	**38**	**12**	**30**	**47**

A patient's treating medical practitioner may also seek to have a patient who has complied with a Treatment Order but who nevertheless requires admission to prevent possible harm taken under escort and involuntarily admitted to and detained in an approved hospital. The circumstances in which this may occur are set out in section 47A of the Act.

A patient's treating medical practitioner may only seek to take action under section 47A if:

- The patient is subject to a Treatment Order that provides for a combination of treatment settings and for the admission and re-admission of the patient to those settings
- The patient has complied with the Treatment Order, and
- The treating medical practitioner is satisfied on reasonable grounds that despite the patient's compliance, the patient's health or safety or the safety of any other person has been, or is likely to be, seriously harmed, and the harm, or likely harm, cannot be adequately addressed except by way of the patient's admission or re-admission to and, if necessary, detention in an approved hospital.

If a patient is admitted to an approved facility under section 47A of the Act, the controlling authority of the approved facility is to notify the Chief Civil Psychiatrist (and the Tribunal) of the patient's admission.

Section 47A of the Act was inserted with effect from 1 July 2017 and the data presented below reflects this.

Admission to prevent possible harm is generally to one of Tasmania's major hospitals – the Royal Hobart Hospital, the Launceston General Hospital and the North West Regional Hospital – Burnie Campus – or to the Roy Fagan Centre.

Figure 10: Admissions to Prevent Possible Harm by Hospital - Action Taken under section 47A of the Act by Hospital for the Period 2017-18

Hospital	2017-18
LGH	21
NWRH – Burnie	20
RHH	32
RFC	3
Total	**76**

Urgent Circumstances Treatment

Urgent circumstances treatment is treatment that is authorised by an approved medical practitioner as being urgently needed in the patient's best interests and that is given without informed consent or Mental Health Tribunal authorisation.

An approved medical practitioner may authorise urgent circumstances treatment if, and only if, he or she has examined the patient and has concluded, from the examination, that:

- The patient has a mental illness that is generally in need of treatment
- The treatment is necessary for the patient's health or safety or the safety of others
- The treatment is likely to be effective and appropriate in terms of the treatment outcomes, and
- Achieving the necessary treatment outcomes 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).

The circumstances in which urgent circumstances treatment may be authorised for and given to an involuntary patient are set out in section 55.

Urgent circumstances treatment may be given for up to 96 hours, until the treatment is completed or an approved medical practitioner stops the treatment, until an Assessment Order, Treatment Order or interim Treatment Order ceases or is discharged, or until the authorisation is set aside by the Tribunal.

An approved medical practitioner who authorises urgent circumstances treatment is to ensure that the patient is advised of the authorisation, that a copy of the authorisation is given to the patient, the Chief Civil Psychiatrist and the Tribunal, and that a copy of the authorisation is placed on the patient's clinical record.

Figure 11: Authorisations of Urgent Circumstances Treatment by Area for the Period 2014 -15 to 2017-18

Area	2014-15	2015-16	2016-17	2017-18
North	340	318	375	321
North West	162	171	195	160
South	342	432	518	477
Interstate	10	12	14	12
Total	**854**	**933**	**1102**	**970**
% Children	1.41%	2.25%	4.63%	1.75%
% Female (all ages)	41.80%	48.55%	51.63%	49.18%
% Male (all ages)	58.20%	51.45%	48.37%	50.10%
% Other (all Ages)	0.00%	0.00%	0.00%	0.72%

Involuntary Patient Leave

An approved medical practitioner may grant an involuntary patient leave of absence from an approved hospital. The leave may be granted for clinical or personal reasons and in the case of leave for personal reasons, an application is required.

Leave may be granted subject to conditions, including that the patient be required to be under escort during the leave or any part of the leave. Leave may also be extended, varied or cancelled. An approved medical practitioner who grants an involuntary patient leave is to give a copy of the leave pass, and any notice extending, varying or cancelling leave, to the patient and the Chief Civil Psychiatrist, amongst others. A copy of leave documentation is also required to be placed on the patient's clinical record.

The circumstances in which leave may be granted, refused, extended, varied or cancelled are set out in section 60 of the Act.

Statistical data is not provided for involuntary patient leave decisions.

Voluntary Inpatients

Under section 136 of the Act, the controlling authority of an approved hospital or approved assessment centre is to provide the Chief Civil Psychiatrist and the Mental Health Tribunal with a monthly report on the accommodation and treatment of people who have been voluntary inpatients for a continuous period of longer than four months. The report is to specify the name and date of admission of each long term voluntary inpatient and details of the treatment and care given in the previous month.

Statistical data is not provided for the admission of long-term voluntary inpatients.

Special Powers of Ambulance Officers and Medical Practitioners acting as Mental Health Officers (Sedation)

Under section 212 of the Act, an ambulance officer or medical practitioner who is approved as a Mental Health Officer under the Act may, when transporting or preparing to transport any patient (or prospective patient) by ambulance under the Act, sedate the patient.

An approved ambulance officer or medical practitioner may only give a patient sedation if the officer reasonably considers it necessary or prudent to do so, having regard to any field protocols approved by the Commissioner of Ambulance Services under the *Poisons Act 1971*. Any sedation that is given must be given in accordance with such protocols.

An approved ambulance officer or medical practitioner who exercises the power of sedation is to give the Chief Civil Psychiatrist a report of the matter.

Statistical data is not provided for the exercise by approved ambulance officers or medical practitioners of the power of sedation.

Chief Forensic Psychiatrist Powers and Functions

Admission of Involuntary Patients to Secure Mental Health Units

The Chief Forensic Psychiatrist's powers and functions in relation to the admission of involuntary patients to secure mental health units have been reported above.

Return of Certain Forensic Patients to Prison or Youth Detention

A prisoner or detainee who appears to be suffering from a mental illness, or who has a disability, may be removed from a prison to a secure mental health unit under section 36A of the *Corrections Act*. This may be because the Director determines that it is in the prisoner or detainee's best interests, or in the best interests of other people in the prison, for the prisoner or detainee to be so removed. In the case of a prisoner or detainee with mental illness, it may also be because the prisoner or detainee has asked to be transferred.

Similarly, a youth detainee who appears to be suffering from a mental illness, or who has a disability, may be removed from a detention centre to a secure mental health unit under section 134A of the *Youth Justice Act*. This may be because the Director determines that it is in the prisoner or detainee's best interests, or in the best interests of other detainees in the detention centre or staff of the detention centre. In the case of a youth detainee with mental illness, it may also be because the detainee has asked to be transferred.

A prisoner or detainee, or youth detainee, who has asked to be transferred to the secure mental health unit and who becomes a forensic patient on that basis may ask to be returned to the custody of the Director, Corrective Services (if the patient is a prisoner or detainee) or to the custody of the Secretary of the Department responsible for the *Youth Justice Act* (if the patient is a youth detainee) at any time.

The Chief Forensic Psychiatrist or a delegate is to have any patient who asks to be returned examined by an approved medical practitioner as soon as possible after receiving the patient's request. The Chief Forensic Psychiatrist or delegate must have regard to the results of the examination and whether or not the reasons for the patient's admission are still valid, as well as such other matters as the Chief Forensic Psychiatrist or delegate considers relevant, before deciding whether to agree to or refuse the request.

The circumstances in which a patient's request to return to prison or youth detention, and the actions required from the Chief Forensic Psychiatrist or delegate on receipt of such a request, are set out in section 70 of the Act.

Any decision by the Chief Forensic Psychiatrist or a delegate to refuse a request is reviewable by the Mental Health Tribunal.

Figure 12: Requests to Return to Prison/Youth Detention for the Period 2014-15 to 2017-18

	2014-15	2015-16	2016-17	2017-18
Request to return to prison	1	0	0	0
% Female (all ages)	0.00%	0.00%	0.00%	0.00%
% Male (all ages)	100.00%	0.00%	0.00%	0.00%

Transfer of Forensic Patients between Secure Mental Health Units

The Chief Forensic Psychiatrist may direct that a forensic patient be transferred from one secure mental health unit to another if satisfied that the transfer is necessary for the patient's health or safety or the safety of others. The circumstances in which this may occur are set out in section 72 of the Act.

Tasmania has one secure mental health unit; as such the powers available to the Chief Forensic Psychiatrist under section 72 of the Act are not utilised.

Transfer of Forensic Patients to Hospitals etc

The Chief Forensic Psychiatrist may direct that a forensic patient be removed from a secure mental health unit to a secure institution, an approved hospital, a health service within the meaning of the *Health Complaints Act 1995*, or premises where such a health service is provided under section 73 of the Act.

Circumstances in which a transfer may be directed under section 73 of the Act include if a patient requires specialist hospital care or to facilitate attendance at allied health, dental or medical appointments which generally occur offsite.

In most cases transfers are planned and authorisation is given by a delegate of the Chief Forensic Psychiatrist.

Figure 13: Forensic Patient transfers to Hospital etc for the Period 2014-15 to 2017-18

	2014-15	2015-16	2016-17	2017-18
Transfer to hospital	0	174	82	35
% Female (all ages)	0.00%	2.30%	1.22%	0.00%
% Male (all ages)	0.00%	97.70%	98.78%	100.00%

Leave of Absence – Forensic Patients

The Chief Forensic Psychiatrist or a delegate may:

- Apply to the Mental Health Tribunal for leave of absence for forensic patients who are subject to restriction orders under section 78 of the Act
- Grant leave of absence to forensic patients who are not subject to restriction orders under section 82 of the Act, and extend, vary or cancel such leave.

The Chief Forensic Psychiatrist or delegate may only apply for leave of absence for forensic patients who are subject to restriction orders for clinical reasons. Clinical reasons are defined in section 3 of the Act to include facilitating the patient's rehabilitation or reintegration into the community, and further the patient's treatment, and reasons deemed appropriate by the person authorised to grant the leave.

The Chief Forensic Psychiatrist or a delegate may grant leave for forensic patients who are not subject to restriction orders for clinical reasons, or personal reasons. Clinical reasons are as described above. Personal reasons include visiting a sick or dying relative or close friend, attending the funeral (or wedding) of a relative or close friend, and attending a reunion or commemoration. Leave for clinical reasons may be granted on the application of the patient's treating medical practitioner while leave for personal reasons may be granted on the application of the patient or another person who, in the opinion of the Chief Forensic Psychiatrist or delegate considering the matter, has a genuine interest in the patient's welfare.

The Chief Forensic Psychiatrist or delegate considering the application is required to notify the Secretary (Corrections) and others of the application and to consider any submissions received, including from registered victims, before deciding whether to grant or refuse leave.

Leave may be granted for a particular purpose, or for a particular period, or both, and may be granted subject to such conditions as the Chief Forensic Psychiatrist or delegate considers necessary or desirable for the patient's health or safety or for the safety of others. This may extend to a requirement that the patient be under escort during the leave or any portion of the leave.
Leave that has been granted may be extended, varied or cancelled. The circumstances in which this may occur are set out in section 79 for forensic patients who are subject to restriction orders and in section 83 for forensic patients who are not subject to restriction orders.

Matters relevant to leave of absence for forensic patients who are subject to restriction orders will be reported by the Mental Health Tribunal in the Tribunal's Annual Report.

Figure 14: Leave of Absence Granted to Forensic Patients who are not subject to Restriction Orders for the Period 2014-15 to 2017-18

	2014-15	2015-16	2016-17	2017-18
Leave of Absence	57	38	9	37
% Female (all ages)	0.00%	0.00%	0.00%	0.00%
% Male (all ages)	100.00%	100.00%	100.00%	100.00%

Seclusion and Restraint

A forensic patient may be placed in seclusion or under physical, mechanical or chemical restraint under the Act in certain, limited circumstances. The circumstances in which a forensic patient may be placed in seclusion are set out in section 94 of the Act while the circumstances in which a forensic patient may be placed under restraint are set out in section 95 of the Act.

A forensic patient may only be placed in seclusion if:

- The seclusion is authorised as being necessary to facilitate the patient's treatment, to ensure the patient's general health care, to ensure the patient's health or safety or the safety of other persons, 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, or facilitate the patient's lawful transfer to or from another facility, or for a reason sanctioned by Chief Forensic Psychiatrist Standing Orders
- The person authorising the seclusion is satisfied that it is a reasonable intervention in the circumstances
- The seclusion lasts for no longer than is authorised, and
- The seclusion is managed in accordance with Chief Forensic Psychiatrist Standing Orders or Clinical Guidelines.

For a child patient (a patient under the age of 18 years), authorisation must come from the Chief Forensic Psychiatrist or a delegate. For other patients, authorisation may be given by the Chief Forensic Psychiatrist or a delegate, a medical practitioner or an approved nurse.

A forensic patient may only be placed under restraint if:

- The restraint is authorised as being necessary to facilitate the patient's treatment, to ensure the patient's general health care, to ensure the patient's health or safety or the safety of other persons, 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, or facilitate the patient's lawful transfer to or from another facility, or for a reason sanctioned by Chief Forensic Psychiatrist Standing Orders
- The person authorising the restraint is satisfied that it is a reasonable intervention in the circumstances
- The restraint lasts for no longer than is authorised
- In the case of mechanical restraint, the means of restraint employed in the particular case is approved in advance by the Chief Forensic Psychiatrist, and
- The restraint is managed in accordance with Chief Forensic Psychiatrist Standing Orders or Clinical Guidelines.

In relation to chemical or mechanical restraint, and the physical restraint of a child (a person under the age of 18 years) authorisation must come from the Chief Forensic Psychiatrist or a delegate. For other cases of physical restraint, authorisation may be given by the Chief Forensic Psychiatrist or a delegate, a medical practitioner or an approved nurse.

Under the Act:

- Mechanical restraint is defined as a device that controls a person's freedom of movement
- Chemical restraint is defined as medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition, and
- Physical restraint is defined to mean bodily force that controls a person's freedom of movement.

Seclusion and restraint are restrictive interventions, and their application 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.

A person who authorises seclusion or restraint is required to make a record of the matter and to give a copy of the record to the patient, the Chief Forensic Psychiatrist and the Mental Health Tribunal. A copy of the record is also required to be placed on the patient's clinical record.

Figure 15: Number of Seclusion Authority Forms received by the Chief Forensic Psychiatrist for the Period 2014-15 to 2017-18

	2014-15	2015-16	2016-17	2017-18
Seclusion	51	40	20	6
% Female (all ages)	9.80%	32.50%	0.00%	0.00%
% Male (all ages)	90.20%	67.50%	100.00%	100.00%

Figure 16: Number of Restraint Authority Forms received by the Chief Forensic Psychiatrist by Type for the Period 2014-15 to 2017-18

	2014-15	2015-16	2016-17	2017-18
Physical	30	37	11	8
Mechanical		2	3	2
Chemical				
Total Restraint	30	39	14	10
% Female (all ages)	3.33%	15.38%	0.00%	0.00%
% Male (all ages)	96.67%	84.62%	100.00%	100.00%

The Mental Health Tribunal has oversight of instances of seclusion and restraint, including instances of seclusion and restraint authorised by the Chief Forensic Psychiatrist or a delegate.

Visits – Cancellation or Suspension of Privileged Visitor, Caller or Correspondent Status

The Act provides for and regulates privileged visitors, callers and correspondents in respect to visits, telephone calls and correspondence.

The Chief Forensic Psychiatrist or delegate may cancel or suspend any individual's privileged visitor, privileged caller, or privileged correspondent status for a time. The circumstances in which this may occur are set out in section 94 of the Act and are limited to circumstances in which the Chief Forensic Psychiatrist or delegate is satisfied on reasonable grounds that the individual has engaged in behaviour that is incompatible with the management, good order or security of a secure mental health unit.

For the period 1 July 2017 – 30 June 2018, the Chief Forensic Psychiatrist did not cancel or suspend any individual's privileged visitor, privileged caller or privileged correspondent status.

Correction of Orders where Validity Not Affected

An error in a Chief Forensic Psychiatrist approved form that does not affect the form's validity may be corrected by the Chief Forensic Psychiatrist.

For the period 1 July 2017 – 30 June 2018, the Chief Forensic Psychiatrist did not correct any errors in Chief Forensic Psychiatrist approved forms.

Functions and Powers under other Acts

The Chief Forensic Psychiatrist has functions and powers under Acts other than the *Mental Health Act 2013*.

A full list of these functions can be found at Appendix 4.

Chief Forensic Psychiatrist Oversight

Urgent Circumstances Treatment

Urgent circumstances treatment is treatment that is authorised by an approved medical practitioner as being urgently needed in the patient's best interests and that is given without informed consent to Mental Health Tribunal authorisation.

An approved medical practitioner may authorise urgent circumstances treatment if, and only if, he or she has examined the patient and has concluded, from the examination, that:

- The patient has a mental illness that is generally in need of treatment
- The treatment is necessary for the patient's health or safety or the safety of others
- The treatment is likely to be effective and appropriate in terms of the treatment outcomes, and
- Achieving the necessary treatment outcomes 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).

The circumstances in which urgent circumstances treatment may be authorised for and given to a forensic patient are set out in section 87 of the Act.

Urgent circumstances treatment may be given for up to 96 hours, until the treatment is completed or an approved medical practitioner stops the treatment, until the authorisation is set aside by the Tribunal, or until the patient is discharged from the secure mental health unit.

An approved medical practitioner who authorises urgent circumstances treatment is to ensure that the patient is advised of the authorisation, that a copy of the authorisation is given to the patient, the Chief Forensic Psychiatrist and the Tribunal, and that a copy of the authorisation is placed on the patient's clinical record.

For the period 1 July 2017 – 30 June 2018, there were no authorisations of urgent circumstance treatment for forensic patients.

Interstate Transfer Agreements

The Minister for Health may enter into interstate transfer agreements and interstate control agreements on behalf of Tasmania. The power to do so is set out in section 201 of the Act. Under section 202 of the Act, an interstate transfer agreement is an agreement between the Minister for Health and the Minister's counterpart in another State or Territory providing for the interstate transfer on humanitarian grounds of eligible patients or any class of eligible patients.

Under section 205 of the Act, an interstate control agreement is an agreement between the Minister for Health and the Minister's counterpart in another State or Territory 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.

The Minister did not enter into any interstate transfer agreements or interstate control agreements on behalf of Tasmania in the period 1 July 2017 – 30 June 2018.

Chapter 4: Profile of Public Mental Health Services in Tasmania

Mental Health Facilities and Services

Public mental health services are provided across Tasmania through Mental Health Services, which is a part of the Tasmanian Health Service. Mental Health Services delivers care to the estimated three per cent of Tasmanians with a severe mental illness through community teams and inpatient settings.

Community Mental Health Services

Community mental health services are 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 Psychiatry (32 bed located at the Royal Hobart Hospital). The inpatient unit at the RHH was moved in November 2016 from the 33 bed unit in B Block to a 32 bed unit in the new temporary J Block to allow for building works on the RHH campus.

Specialist extended treatment facilities are located in the south and provide statewide services including Millbrook Rise Centre (27 beds), Roy Fagan Centre (32 beds), Mistral Place (10 beds) and Tolosa Street Units (12 beds).

Forensic Mental Health Services

Forensic Mental Health Services provides community and inpatient mental health assessment, treatment and case management for offenders or people at risk of offending who have a mental disorder. Services are delivered across three streams – inpatient forensic mental health services, community forensic mental health services and the court liaison service.

Inpatient Forensic Mental Health Services

Inpatient Forensic Mental Health Services are provided at Tasmania's secure mental health unit, the Wilfred Lopes Centre (WLC). The Centre is located at Risdon, near to the Risdon Prison complex. Patients admitted to WLC 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 who require specialist mental health inpatient treatment.

Community Forensic Mental Health Services

Community Forensic Mental Health Services are provided through community teams located in the North and South of the State and include community case management and services to the Tasmania Prison Service.

Court Liaison Services

The Court Liaison Service assists in the assessment and identification of people who are appearing before the courts who may not be fit to plead or who are thought to require diversion into a mental health setting through the Mental Health Diversion List (MHDL).

Use of the Mental Health Act 2013 for People under the Age of 18

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, however situations in which the most appropriate form of treatment for young people is for them to be nursed one to one in an adult mental health unit until it becomes clinically appropriate to treat the young person either on a paediatric ward or back in the community.

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 is 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.

The Chief Psychiatrists have a role in oversighting the treatment of children under the Act.

Electroconvulsive Therapy

The Act does not specifically regulate Electroconvulsive Therapy (ECT) – rather, ECT is dealt with as a form of treatment which may be given with consent or if authorised under the Act.

ECT is a therapeutic medical procedure for the treatment of severe mental disorders. It has an established 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 for many people is potentially life-saving.

ECT, while accepted by mental health clinicians, the Royal Australian and New Zealand College 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 for Health with relevant background and factual data.

ECT involves the delivery of an electrical current to induce a seizure for therapeutic purposes that have been previously outlined. 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 anaesthetised. 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 or from an approved medical practitioner if ECT is given as urgent circumstances treatment.

Figure 17: Number of ECT treatments by Discharge Location for the Period 2017-2018

	Total Episodes (Discharged) with ECT Procedure	Unique Patient Count
LGH	144	26
NWRH – Burnie	147	27
RHH	553	74
Statewide and Mental Health Services	11	10
TOTAL	**855**	**137**

Chapter 5: Chief Psychiatrist Direct Interventions

The Chief Civil Psychiatrist and Chief Forensic Psychiatrist each have the power to intervene directly with regard to the assessment, treatment and care of patients under the Act in certain circumstances.

The Chief Civil Psychiatrist has the power to intervene directly with regard to the assessment, treatment or care of voluntary inpatients or involuntary patients in relation to:

- The use of seclusion and restraint
- The granting, refusal, and control of leaves of absence
- The giving or withholding of patient information
- Assessment and treatment generally
- Matters prescribed by the regulations.

The Act defines voluntary inpatient to mean a person who has been admitted to a facility involuntarily to receive treatment for a mental illness and is receiving that treatment on the basis of informed consent.

The Chief Forensic Psychiatrist has, in turn, the power to intervene directly with regard to the assessment, treatment and care of forensic patients in relation to:

- The use of seclusion and restraint
- The use of force
- The granting, refusal, and control of leaves of absence
- The giving or withholding of patient information
- The granting, denial, and control of visiting, correspondence and telephone rights
- Assessment and treatment generally
- Matters prescribed by the regulations.

It should be noted that no matters are prescribed by the regulations.

The power of intervention may be exercised on the relevant Chief Civil Psychiatrist's own motion, at the request of the patient or at the request of any person who, in the opinion of the Chief Civil Psychiatrist, has a proper interest in the patient's health, safety or welfare but only if the Chief Civil Psychiatrist has made inquiries into the relevant matter and is satisfied from those inquiries that intervention is essential to the patient's health, safety or welfare.

Matters relevant to the Chief Civil Psychiatrist's power of direct intervention are set out in section 147 of the Act.

For the period 1 July 2017 – 30 June 2018, the Chief Psychiatrists did not exercise the power of direct intervention.

Appendix 1: List of Forms Approved by the Chief Civil Psychiatrist and Chief Forensic Psychiatrist since the introduction of the Mental Health Act 2013 and in place as at 30 June 2018

Since the introduction of the Act, the Chief Civil Psychiatrist (CCP) has approved the following Forms:

- CCP Approved Form 2A – Capacity (Adults)
- CCP Approved Form 2B – Capacity (Children)
- CCP Approved Form 4 – Protective Custody
- CCP Approved Form 5 – Application for Assessment Order (NB: this form is no longer in use)
- CCP Approved Form 6 – Assessment Order
- CCP Approved Form 7 – Treatment Plan
- CCP Approved Form 8 – Urgent Circumstances Treatment (Involuntary)
- CCP Approved Form 9 – Seclusion Authorisation (Involuntary)
- CCP Approved Form 10 – Restraint Authorisation (Involuntary)
- CCP Approved Form 11 – Application for Personal Leave (Involuntary)
- CCP Approved Form 12A – Leave Granted or Refused (Involuntary)
- CCP Approved Form 12B – Leave Cancelled (Involuntary)
- CCP Approved Form 12C – Leave Not Complied With (Involuntary)
- CCP Approved Form 13 – Involuntary Patient Transfer Between Hospitals
- CCP Approved Form 19 – Transfer of Involuntary Patient to SMHU
- CCP Approved Form 22 – Failure to Comply with Treatment Order – Admission to Hospital
- CCP Approved Form 23 – Admission to Prevent Possible Harm
- CCP Approved Form 24 – Escort to Hospital

Since the introduction of the Act, the Chief Forensic Psychiatrist (CFP) has approved the following Forms:

- CFP Approved Form 8 – Urgent Circumstances Treatment (Forensic)
- CFP Approved Form 9 – Seclusion Authorisation (Forensic)
- CFP Approved Form 10 – Restraint Authorisation (Forensic)
- CFP Approved Form 12A – Leave Application – Non-Restriction Order (Forensic)
- CFP Approved Form 12B – Leave Granted or Refused – Non-Restriction Order (Forensic)
- CFP Approved Form 12C – Cancellation of Leave (Forensic)
- CFP Approved Form 17 – Forensic Patient Transfer to Hospital
- CFP Approved Form 18 – Cancellation or Suspension of Visits
- CFP Approved Form 20A – Request to Return to Prison (Forensic)
- CFP Approved Form 20B – Forensic Patient Return to Youth Detention

Appendix 2: List of Standing Orders and Clinical Guidelines Introduced by the Chief Civil Psychiatrist and Chief Forensic Psychiatrist since the introduction of the *Mental Health Act 2013* and in place as at 30 June 2018

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 CCP 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 CFP 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 3: Full List of Functions Undertaken By the Chief Civil Psychiatrist under the *Criminal Justice (Mental Impairment) Act 1999* and *Sentencing Act 1997*

Under the *Criminal Justice (Mental Impairment) Act 1999* (Tasmania), the Chief Civil Psychiatrist has a role in informing the Attorney General of the subsequent fitness to stand trial of a defendant who has been found unfit to stand trial and in respect of whom the Court has made a Treatment Order (section 29).

The Chief Civil Psychiatrist's functions under the *Sentencing Act 1997* (Tasmania) are to provide advice to a court that finds a person guilty of an offence, in circumstances where it is proposed to admit the person to an approved hospital (sections 72 and 75).

Appendix 4: Full List of Functions Undertaken By the Chief Forensic Psychiatrist under Acts Other Than the *Mental Health Act 2013*

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

- Applying to the Court for an order under section 21A relating to breach of conditions on release (section 21A)
- Applying to the Supreme Court for discharge of a restriction order (section 26)
- Preparing and submitting a report to the Supreme Court relating to a defendant for the purposes of a hearing by the Court for discharge of a restriction order (section 26)
- Informing the Attorney General of the subsequent fitness to stand trial of a defendant who has been found unfit to stand trial and in respect of whom the Court has made a restriction order or a supervision order (section 29)
- Supervising people subject to supervision orders (section 29A)
- Notifying the Mental Health Tribunal if a defendant who is subject to a supervision order objects to taking medication or to the administration of medical treatment as required by or under a supervision order (section 29A)
- Applying to the Supreme Court for variation or revocation of a supervision order (section 30)
- Providing a report to the Supreme Court on specified matters if ordered to do so by the Court before the Court's determination of an application for variation or revocation of a supervision order (section 30)
- Apprehending a defendant who is subject to a supervision order (section 31)
- Being notified that a defendant who is subject to a supervision order has been apprehended, if the person who has apprehended the defendant is not the Chief Forensic Psychiatrist (section 31)
- Authorising the admission to a secure mental health unit of a defendant who has been apprehended for a period exceeding 24 hours (section 31)
- Approving medical practitioners as persons holding the requisite training and experience to provide medico-legal reports to the Court (section 35)
- Providing reports to the Court relating to the detention of a defendant in a secure mental health unit before proceedings are completed (section 39)
- Providing reports to the Court relating to the making of restriction orders that commit a person who has not attained the age of 18 years to a secure mental health unit (section 39A) Authorising persons for the purposes of any or all of the provisions of the *Criminal Justice (Mental Impairment) Act* (section 41A).

The Chief Forensic Psychiatrist's functions under the *Sentencing Act 1997* (Tasmania) are to provide advice to a court that finds a person guilty of an offence, in circumstances where it is proposed to admit the person to a secure mental health unit (sections 72 and 75).

The Chief Forensic Psychiatrist's functions under the *Criminal Code Act 1924* (Tasmania) are to provide a report to the Court relating to the committal of an accused person to a secure mental health unit and applying for the variation or revocation of an order that commits an accused person to a secure mental health unit (section 348).

The Chief Forensic Psychiatrist's functions under the *Justices Act 1959* (Tasmania) are to provide a report to a justice with the power to remand a defendant in custody relating to the committal of the defendant to a secure mental health unit and applying for the variation or revocation of an order that commits a defendant to a secure mental health unit (section 47).

The Chief Forensic Psychiatrist's functions under the *Corrections Act 1997* (Tasmania) relate to decisions to admit prisoners or detainees to a secure mental health unit under section 36A of the *Corrections Act*. The Chief Forensic Psychiatrist may also be required to provide a report to the Parole Board relating to the release on parole of a prisoner who is or has been a forensic patient under section 72 of the *Corrections Act*.

The Chief Forensic Psychiatrist's functions under the *Youth Justice Act 1997* (Tasmania) relate to:

- Reporting to Courts relating to proposals to commit a youth who has not attained the age of 18 years to a secure mental health unit (section 105)
- Decisions to admit youth detainees to a secure mental health unit (section 134A).