ANNUAL REPORT 2018–19

CHIEF CIVIL PSYCHIATRIST

CHIEF FORENSIC PSYCHIATRIST

Office of the Chief Psychiatrist
Department of Health

Tasmanian Government

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CHIEF PSYCHIATRIST'S MESSAGE

I am pleased to present this Annual Report of the Chief Civil Psychiatrist and Chief Forensic Psychiatrist in accordance with section 150 of the *Mental Health Act 2013* (Tas) (the Act) for the period 1 July 2018 – 30 June 2019.

This report, my second as Chief Civil Psychiatrist and Chief Forensic Psychiatrist for Tasmania, provides an outline of the Chief Psychiatrists' activities during the 2018 – 2019 Financial Year. It reports on the statutory functions of the Chief Psychiatrists under the Act and makes observations and presents data about these functions. It also provides an overview of other work that I have undertaken as the incumbent to the offices of the Chief Civil Psychiatrist and Chief Forensic Psychiatrist within the broader mental health sector in Tasmania.

The past Financial Year has been very busy with a range of exciting and transformative activities. The 12th Towards Eliminating Restrictive Practices Forum was held in Hobart during November 2018 following several months of planning and preparation. The Mental Health Hospital in the Home Program commenced in March 2019. The Prisoner Mental Health Care Taskforce Final Report was completed in March 2019 and the Mental Health Integration Taskforce Final Report was completed in April 2019. All of this occurred alongside concerted efforts (in collaboration with Queensland and on behalf of the Safety and Quality Partnership Standing Committee) to address long-standing issues associated with people on mental health orders who move jurisdiction.

This work has established the foundations for significant reform and innovation in the delivery of mental health services across our State, and nationally, in the coming years. I am optimistic for what lies ahead.

This coming Financial Year will also see a review of the Act's operation. When the Act commenced in February 2014 it was rightly thought to represent a significant reform in how people who live with severe mental illness are assessed and treated. The Tasmanian Parliament recognised this and included a requirement that the Minister for Mental Health and Wellbeing review the Act's operation after six years of it commencing. I will have the great pleasure, as Chair of the 2020 Review Project Steering Committee, to be leading the review on the Minister's behalf.

The review is an important opportunity for people with lived experience of the Act, their family members, friends and carers, clinicians and others to share their experiences of the Act's operation, and to let us know what they think. I am looking forward to hearing people's views and reporting on these in the next Annual Report.

I would like to extend my thanks to Professor Ken Kirkby, who has acted as Chief Civil Psychiatrist and Chief Forensic Psychiatrist at times when I have been unable to do so, and to staff of my Office, and of the Mental Health Alcohol and Drug Directorate within the Department of Health, without whom I could not perform my functions.

Thanks also go 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.

It should be noted that 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.

Lastly, a final comment on data. It is usual in Annual Reports to make comment on statistical trends. An unfortunate loss of data over a period of approximately three weeks has compromised the ability to comprehensively compare data with data from previous years. Despite this, the statistical data suggests a general overall downward trend in the number of interventions under the Act. The reason for the loss of data is unclear, however rigorous tracking efforts implemented since then will prevent these occurrences from happening in the future.

Dr Aaron Robert Groves
Chief Civil Psychiatrist and Chief Forensic Psychiatrist

25th September 2019

CHAPTER 1: BACKGROUND AND OVERVIEW

BACKGROUND

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

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

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

The Act is intended to be rights-focussed, and to reflect notions of consumer autonomy. It establishes what is effectively a substitute decision-making framework for people with mental illness who, because of the illness, lack decision-making capacity and cannot make their own assessment and treatment decisions.

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

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

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

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

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

Other more recent amendments to the Act include:

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

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

OVERVIEW OF THE ACT

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

- Chapter 1 of the Act defines key terms, confirms how particular concepts underpinning the Act's provisions are to be interpreted and identifies the Act's objects, status and principles
- Chapter 2 of the Act provides for the assessment, treatment and management of patients
    - Part 1 of Chapter 2 of the Act refers to the mental health service delivery principles and identifies the circumstances in which a patient may be given treatment.
    - Part 2 of Chapter 2 of the Act applies to and regulates protective custody.
    - Part 3 of Chapter 2 of the Act applies to involuntary patients. It provides for and regulates Assessment Orders, Treatment Orders, treatment plans, urgent circumstances treatment, seclusion and restraint, patient movements and the circumstances in which an involuntary patient can be admitted to a secure mental health unit. It also sets out the rights of involuntary patients under the Act.
    - Part 4 of Chapter 2 of the Act applies to the admission and custody of forensic patients and regulates forensic patient leave.
    - Part 5 of Chapter 2 of the Act applies to the treatment and management of forensic patients. Amongst other matters it provides for and regulates force, seclusion and restraint, visits, telephone calls and mail, searches, and judicial and related matters. It also sets out the rights of forensic patients under the Act.
    - Part 6 of Chapter 2 of the Act applies to special psychiatric treatment.
    - Part 7 of Chapter 2 of the Act applies to information management and related matters.
    - Part 8 of Chapter 2 of the Act applies to approved personnel and facilities.
- Chapter 3 of the Act provides for oversight and review
    - Part 1 of Chapter 3 provides for the appointment and features of office of the Chief Psychiatrists and for Clinical Guidelines and Standing Orders.
    - Part 2 of Chapter 3 provides for the appointment, powers and functions of Official Visitors, and for visits, complaints and reporting mechanisms.

- Part 3 of Chapter 3 provides for the establishment, functions and powers of the Mental Health Tribunal. It also provides for the Tribunal's review functions.

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

ABOUT THE CHIEF CIVIL PSYCHIATRIST AND CHIEF FORENSIC PSYCHIATRIST

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

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

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

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

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

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

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

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

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

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

Matters relating to the offices of Chief Civil Psychiatrist and Chief Forensic Psychiatrist are set out in Chapter 2 of this document while the Chief Civil Psychiatrist and Chief Forensic Psychiatrist's powers and functions, and their oversight and review responsibilities, are explored further in Chapters 3 and 4 respectively.

CHAPTER 2: ADMINISTRATION OF THE *MENTAL HEALTH ACT 2013*

This Chapter provides information on the offices of Chief Civil Psychiatrist and Chief Forensic Psychiatrist, and on administration of the *Mental Health Act 2013* (the Act).

CHIEF CIVIL PSYCHIATRIST AND CHIEF FORENSIC PSYCHIATRIST

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

Under section 143 of the Act, the Governor may appoint a person with at least five years' experience in practising psychiatry to be Chief Civil Psychiatrist. Under section 144 of the Act, the Governor may, in turn, appoint a person with at least five years' experience in practising psychiatry to be Chief Forensic Psychiatrist.

Each of the Chief Psychiatrists is appointed by the Governor and holds office for a term of up to five years.

Dr Aaron 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.

APPROVED PERSONNEL

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

Approved medical practitioners are people who have been approved as medical practitioners for provisions of the Act within the Chief Psychiatrists' jurisdiction and for provisions of other Acts under which the relevant Chief Psychiatrist has responsibilities.

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

- Affirming and discharging Assessment Orders
- Assessing people subject to Assessment Orders to confirm whether the assessment criteria and treatment criteria are met
- 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, and
- Examining patients placed in seclusion or under restraint.

The Chief Psychiatrists may approve people individually. Alternatively, the Chief Psychiatrists may approve all members of a class of people. The power to do so is set out in section 138 of the Act.

There are limitations on who can be approved as a medical practitioner, and only people who are either psychiatrists, or medical practitioners who are otherwise qualified or experienced in the diagnosis or treatment of mental illness, can be approved.

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

Approved nurses are people who have been approved as nurses for provisions of the Act within the Chief Psychiatrists' jurisdiction and for provisions of other Acts under which the relevant Chief Psychiatrist has responsibilities.

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

The Chief Psychiatrists may approve people as nurses individually. Alternatively, the Chief Psychiatrists may approve all members of a class of people as approved nurses. As with approved medical practitioners, the power to approve a person as an approved nurse, or all members of a class of people as approved nurses, is set out in section 138 of the Act.

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

Approval of a person as a medical practitioner, or as a nurse, takes effect on the day the approval is given or a later day, if specified, and remains in effect for five years unless sooner revoked.

For the period 1 July 2018 to 30 June 2019:

- 135 people were approved as medical practitioners for purposes of the provisions of the Act within the Chief Psychiatrists' jurisdiction
- No classes of people were approved as medical practitioners for the purposes of the provisions of the Act within the Chief Psychiatrists' jurisdiction
- One approval of a person as a medical practitioner for the purposes of provisions of the Act within the Chief Psychiatrists' jurisdiction was revoked
- Three people were approved as nurses for provisions of the Act within the Chief Psychiatrists' jurisdictions
- Two classes of people were approved as nurses for the purposes of relevant provisions of the Act, and
- No approvals of people as nurses for provisions of the Act within the Chief Psychiatrists' jurisdiction were revoked.

MENTAL HEALTH OFFICERS

The Act provides for mental health officers.

Mental health officers are people who have been approved by a Chief Psychiatrist for provisions of the Act within the Chief Psychiatrists' jurisdiction, and for provisions of any other Act in respect of which the relevant Chief Psychiatrist may have responsibilities.

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, and
- Conduct a frisk or ordinary search of a person 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.

The Chief Psychiatrists may approve people as mental health officers individually. Alternatively, the Chief Psychiatrists may approve all members of a class of people as mental health officers. The power to approve a person as a mental health officer, or all members of a class of people as mental health officers, is set out in section 139 of the Act.

As is also the case with approved medical practitioners and approved nurses, there are limitations on who can be approved as a mental health officer, and only people who have skills, qualifications or experience relevant to the responsibilities of mental health officers under relevant provisions of the Act can be approved.

Approval may also be conferred on ambulance officers with the consent of the Commissioner of Ambulance Services under the *Ambulance Service Act 1982* (Tas) and on police officers with the consent of the Commissioner of Police.

Approval of a person as a mental health officer takes effect on the day the approval is given or on a later day, if specified, and remains in effect for five years unless sooner revoked.

For the period 1 July 2018 to 30 June 2019:

- 18 ambulance officers were approved as mental health officers for the Act
- 341 people other than ambulance officers were approved as mental health officers for the Act
- No police officers were approved as mental health officers for the Act, and
- There were no revocations of ambulance officers or other people previously approved.

AUTHORISED PERSONS

The Act also provides for 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 the power to:

- Transport an involuntary patient from an approved hospital to a secure mental health unit in relevant circumstances
- Transport a forensic patient from a secure mental health unit to an approved hospital, secure institution, health service or premises from which a health service is provided in relevant circumstances
- 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, and
- 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 to be an authorised person for the purposes of relevant provisions of the Act individually. The Chief Forensic Psychiatrist or controlling authority may also approve all members of a class of people, for the purposes of relevant provisions of the Act. The power to do this is set out in section 109 of the Act.

For the period 1 July 2018 to 30 June 2019:

- No people were authorised under section 109 of the Act, and
- 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 2018 – 30 June 2019, no new forms were approved.

A list of forms that have been approved by the Chief Civil Psychiatrist and Chief Forensic Psychiatrist since the Act's commencement in 2014, and that were in place on 30 June 2019 can be found at Appendix 1.

STANDING ORDERS AND CLINICAL GUIDELINES

Clinical Guidelines and 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 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 may have responsibilities. The power to do so is set out in section 151 of the Act.

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.

Each of the Chief Psychiatrists may also 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 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 may have responsibilities. The power to do so is set out in section 152 of the Act.

A person exercising responsibilities in respect of a matter for which Standing Orders have been issued must comply with those 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.

For the period 1 July 2018 – 30 June 2019, 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.

For the period 1 July 2018 – 30 June 2019, one new Clinical Guideline was issued: Chief Civil Psychiatrist Clinical Guideline 7. Clinical Guideline 7 relates to the use of off-label medications in the treatment of patients under the Act.

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 2019 can be found at Appendix 2.

STATEMENTS OF RIGHTS

Each of the Chief Psychiatrists has responsibility for approving the form of Statements of Rights required to be given to patients in relevant circumstances under the Act.

The Statements of Rights approved since the Act's commencement in 2014, and in place as at 30 June 2019 are as follows:

- *Your Rights as an Involuntary Patient – Tasmania's Mental Health Act 2013*
- *Your Rights as a Forensic Patient – Tasmania's Mental Health Act 2013*
- *Your Rights if you are Secluded or Restrained under Tasmania's Mental Health Act 2013.*

The Statements of Rights can be accessed online from here:
www.dhhs.tas.gov.au/mentalhealth/mental_health_act/mental_health_act_2013_new_mental_health_act/information_for_consumers,_carers_and_the_community_sector

DELEGATIONS

The Chief Psychiatrists 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, to direct patient transfers, and the power to make decisions about admitting involuntary patients to or detaining involuntary patients at the secure mental health unit.

Under the *Acts Interpretation Act 1931* (Tas), powers and functions may be delegated to a person by name, or to the holder of a particular office or position by reference to the title of the office or position concerned.

For the period 1 July 2018 – 30 June 2019, the Chief Civil Psychiatrist delegated certain of his powers and functions under the Act and the *Sentencing Act 1997* (Tas) to:

- The person or people holding particular offices or positions on five occasions (14 August 2018, 27 September 2018, 4 October 2018, 20 November 2018 and 12 February 2019), and
- People by name on 71 occasions.

For the period 1 July 2018 – 30 June 2019, the Chief Forensic Psychiatrist delegated certain of his powers and functions under the Act, the *Criminal Justice (Mental Impairment) Act 1999* (Tas), the *Corrections Act 1997* (Tas), the *Youth Justice Act 1997* (Tas), the *Criminal Code Act 1924* (Tas), the *Justices Act 1959* (Tas) and the *Sentencing Act* to:

- The person or people holding particular offices or positions on two occasions (27 September 2018 and 4 October 2018), and
- People by name on 15 occasions.

The Minister administering the Act may delegate any of his or her responsibilities under the Act other than the power or delegation and the power to approve facilities and secure institutions under sections 140 and 142 of the Act respectively. The Minister's power of delegation is set out in section 220 of the Act.

As at 30 June 2019, the Act was administered by the Minister for Health other than Parts 2 and 3 of Chapter 3, and Schedules 3, 4 and 5, which were administered by the Minister for Justice.

The controlling authority of an approved facility may also delegate any of the controlling authority's responsibilities under the Act or any other Act, other than the power of delegation. For approved facilities run by or on behalf of the State, the controlling authority is the Secretary, Department of Health. The controlling authority's power or delegation is set out in section 221 of the Act.

For the period 1 July 2018 – 30 June 2019, neither the Ministers nor the controlling authority delegated any of their powers and functions under the Act.

CHAPTER 3: CHIEF CIVIL PSYCHIATRIST

The Chief Civil Psychiatrist has the functions given to him by the Act and by other Acts, and the power to do anything necessary or convenient to be done to perform these functions. This includes ensuring that each involuntary patient has a treatment plan, authorising seclusion and physical restraint for child patients, authorising chemical or mechanical restraint for child and adult patients, authorising patient transfers (including involuntary patient admissions to the secure mental health unit), correcting errors in forms that do not affect the form's validity and intervening directly regarding the assessment, treatment and care of involuntary patients and voluntary inpatients.

The Chief Civil Psychiatrist has general overall responsibility, under and to the Minister responsible for administration of the Act, for ensuring that the objects of the Act are met in respect of involuntary patients, forensic patients and forensic inpatients, and for the running of approved hospitals and approved assessment centres. This responsibility is set out in section 143 of the Act.

The Chief Civil Psychiatrist also has a significant oversight and review responsibility in respect of decisions made by approved medical practitioners, approved nurses and others in respect of involuntary patients and voluntary inpatients.

This responsibility is facilitated through a requirement that information relating to decisions made under the Act by approved medical practitioners and others is provided to the Chief Civil Psychiatrist as appropriate.

This Chapter reports on the exercise by the Chief Civil Psychiatrist of the powers and functions given to him by the Act and by other Acts. It also provides information on matters reported to the Chief Civil Psychiatrist as is required by the Act.

CHIEF CIVIL PSYCHIATRIST POWERS AND FUNCTIONS

TREATMENT PLANS

Under the Act, a treatment plan is a document that outlines the treatment a patient is to receive.

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 medical practitioner may also, after consulting the patient, consult with other people as the medical practitioner thinks fit in the circumstances. This may include the patient's family, friends, 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. A copy of the plan must also be given to the Chief Civil Psychiatrist.

Figure 1: Treatment Plans by Region

Area	2014-15	2015-16	2016-17	2017-18	2018-19
North	247	216	206	122	126
North West	143	149	189	167	120
South	396	428	374	374	307

Area	2014-15	2015-16	2016-17	2017-18	2018-19
Interstate	10	9	11	6	5
Total	**796**	**802**	**780**	**669**	**558**
% Children	0.75%	0.50%	1.79%	1.20%	0.72%
% Female (all ages)	42.59%	45.39%	42.56%	43.35%	43.37%
% Male (all ages)	57.41%	54.61%	57.44%	56.65%	56.63%

SECLUSION AND RESTRAINT

Involuntary patients may be placed in seclusion or under restraint pursuant to the Act in certain, limited circumstances. The circumstances in which an involuntary patient may be placed in seclusion or under restraint are set out in sections 56 and 57 of the Act respectively.

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

- 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 others, or to provide for the management, good order or security of an 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, and
- The seclusion is managed in accordance with any relevant Chief Civil Psychiatrist Standing Orders or Clinical Guidelines.

For a child patient (a patient who is under the age of 18), seclusion may only be authorised by the Chief Civil Psychiatrist or a delegate. For other patients, authorisation may be given by the Chief Civil Psychiatrist or a delegate, or by 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 if:

- 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, and
- The restraint is managed in accordance with any relevant 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), the restraint may only be authorised by the Chief Civil Psychiatrist or a delegate. In

other cases, and for other patients, authorisation may be given by the Chief Civil Psychiatrist or a delegate, or by a medical practitioner or an approved nurse.

Under the Act:

- Mechanical restraint means a device that controls a person's freedom of movement
- Chemical restraint means medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition, and
- Physical restraint means 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 2018 – 30 June 2019, two notifications of a child being secluded were received. One notification related to the Launceston General Hospital and one notification related to the Royal Hobart Hospital.

The median time spent in seclusion was 110 minutes, with the most common reason being to facilitate the patient's treatment (38.97%), and to ensure the patient's health or safety (36.76%).

Figure 2: Occasions of Seclusion by Hospital for the period 2014-15 to 2018 - 19

Area	2014-15	2015-16	2016-17	2017-18	2018-19
LGH	105	77	30	25	28
NWRH	57	20	26	17	19
RHH	275	181	195	91	81
MRC	n.a.	19	10	3	7
Roy Fagan Centre	n.a.	0	1	1	1
Total	**437**	**297**	**262**	**137**	**136**
% Female (all ages)	37.30%	50.84%	66.41%	41.61%	44.85%
% Male (all ages)	62.70%	49.16%	33.59%	58.39%	55.15%
% Other (all Ages)	0%	0%	0%	0%	0%

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

For the period 1 July 2018 – 30 June 2019, eight notifications of a child being restrained were received. Five of these related to the Launceston General Hospital and three related to the North West Regional Hospital – Burnie Campus.

The median time for a patient to be physically restrained was three minutes, with the most common reason being to facilitate the patient's treatment (52.42%) and ensure the patient's health or safety (26.43%).

Figure 3: Occasions of Restraint by Hospital and Type for the period 2014-15 to 2018-19

Area	2014-15	2015-16	2016-17	2017-18	2018-19
LGH	**58**	**53**	**90**	**56**	**83**
Mechanical	4	5	3	5	5
Physical	50	48	85	51	73
Chemical	4	0	2	0	5
NWRH	**57**	**48**	**54**	**76**	**46**
Mechanical	2	3	2	8	9
Physical	55	43	48	65	34
Chemical		2	4	3	3
RHH	**143**	**221**	**171**	**118**	**85**
Mechanical	2	25	8	4	1
Physical	139	194	160	111	78
Chemical	2	2	3	3	6
Millbrook Rise Centre	**0**	**20**	**6**	**5**	**13**
Mechanical	0	0	0	0	0
Physical	0	20	6	5	12
Chemical	0	0	0	0	1
Roy Fagan Centre	**0**	**0**	**3**	**0**	**0**
Mechanical	0	0	0	0	0
Physical	0	0	3	0	0
Chemical	0	0	0	0	0
State Total	**258**	**342**	**324**	**255**	**227**
Mechanical	8	33	13	17	15
Physical	244	305	302	232	197
Chemical	6	4	9	6	15
Mechanical Female	50.00%	27.27%	61.54%	41.18%	13.33%
Mechanical Male	50.00%	72.73%	38.46%	58.82%	86.67%
Physical Female	58.20%	58.36%	65.56%	56.03%	48.73%
Physical Male	41.80%	41.64%	34.44%	43.97%	51.27%
Chemical Female	50.00%	50.00%	44.44%	33.33%	40.00%
Chemical Male	50.00%	50.00%	55.56%	66.67%	60.00%

No new means of restraint were approved by the Chief Civil Psychiatrist during the 2018 –2019 Financial Year.

TRANSFER OF INVOLUNTARY PATIENTS BETWEEN HOSPITALS

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

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

A transfer direction issued by the Chief Civil Psychiatrist or a delegate in accordance with section 59 is authority for a mental health officer to take the person under escort, for the mental health officer to remove the person from the transferring hospital and for the mental health officer to take the person to the other hospital.

Once the person has been transferred, any Assessment Order or Treatment Order that the person is subject to has effect as if it provided for the person's involuntary admission to, and if necessary, detention in, the new approved hospital. For the period 1 July 2018 – 30 June 2019, no children were transferred.

Figure 4: Involuntary Patient Transfers between Facilities

Hospital	Destination Hospital	2014-15	2015-16	2016-17	2017-18	2018-19
LGH	RHH	13	4	4	1	1
LGH	NWRH	8	1	15	18	7
NWRH	RHH	5	0	5	2	0
NWRH	LGH	10	1	16	9	6
RHH	LGH	3	0	3	3	4
RHH	NWRH	1	0	5	2	2
Total Transfers		40	6	48	35	20

POWER OF DIRECT INTERVENTION

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, and
- Matters prescribed by the regulations.

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

Under the Act, a voluntary inpatient is a person who has been admitted to a facility voluntarily to receive treatment for a mental illness and is receiving that treatment with informed consent.

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

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

The Chief Civil Psychiatrist cannot however issue directions which are repugnant to any provision of the Act or of any other Act, or to an order, determination or direction of the Mental Health Tribunal or any Court. This effectively prevents the Chief Civil Psychiatrist from using the power of direct intervention to achieve an outcome that would be contrary to the Act's provisions.

The Mental Health Tribunal has jurisdiction to review decisions made by the Chief Civil Psychiatrist under section 146 of the Act.

For the period 1 July 2018 – 30 June 2019, the Chief Civil Psychiatrist received four requests to exercise the power of direct intervention under section 147 of the Act.

For the period 1 July 2018 – 30 June 2019, the Chief Civil Psychiatrist also made inquiries into matters concerning one patient with a view to exercising the power of direct intervention on the Chief Civil Psychiatrist's own motion in respect of that patient.

In each case the Chief Civil Psychiatrist made inquiries into the relevant matters but was not satisfied from the inquiries that intervention was essential to the patient's health, safety or welfare.

CORRECTION OF ORDERS WHERE VALIDITY NOT AFFECTED

Under section 224 of the Act, 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 or a delegate.

For the period 1 July 2018 – 30 June 2019, 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 under the Act 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 people is likely to be at risk if the person is not taken into protective custody.

The meaning of mental illness is set out in section 4 of the Act.

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 another mental health officer or police officer escorts the person. 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
- The person has been at an approved assessment centre for four hours and none of these things has occurred.

A mental health officer or police officer who takes a person into protective custody, a mental health officer or police officer who releases a person from protective custody and a medical practitioner who examines a person in protective custody are each to make an appropriate record of the matter.

A mental health officer or police officer who releases a person from protective custody is to give the person, and the Chief Civil Psychiatrist, a copy of the record that is made, and a medical practitioner who examines a person in protective custody is to place a copy of the record 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 5: Number of People taken into Protective Custody by Region

Area	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
North	37	92	111	113	126	133
North West	32	89	118	175	197	186

Area	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
South	61	171	192	214	211	219
Interstate	2	5	4	7	10	6
Total	**132**	**357**	**425**	**509**	**544**	**544**
% Children	0.76%	2.52%	4.24%	6.29%	6.07%	7.17%
% Female (all ages)	50.76%	40.62%	46.35%	47.94%	47.79%	46.69%
%Male (all ages)	49.24%	59.38%	53.65%	52.06%	52.21%	53.31%

ASSESSMENT ORDERS

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; and 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, to the Chief Civil Psychiatrist and to 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

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 act 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
    - the failure in compliance has seriously harmed, or is likely to seriously harm, the patient's health or safety or the safety of other people, and
    - 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.

Admission in the event of failure to comply is generally to the Royal Hobart Hospital, the Launceston General Hospital or the North West Regional Hospital – Burnie Campus.

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.

Figure 6: Failures to Comply with Treatment Orders – Action Taken under section 47 of the Act by Facility

Hospital	2014-15	2015-16	2016-17	2017-18	2018-19
LGH	9	6	11	8	3

Hospital	2014-15	2015-16	2016-17	2017-18	2018-19
NWRH	10	1	6	11	7
RHH	19	5	13	28	13
Total	**38**	**12**	**30**	**47**	**23**

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 act 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.

Admission to prevent possible harm is generally to the Royal Hobart Hospital, the Launceston General Hospital or the North West Regional Hospital – Burnie Campus.

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.

Figure 7: Admissions to Prevent Possible Harm - Action Taken under section 47A of the Act by Region

Hospital	2017-18	2018-19
LGH	21	30
NWRH	20	11
RHH	32	45
Roy Fagan	3	0
Total	**76**	**86**

NOTE: Section 47A was inserted to the Act with effect from 1 July 2017 and the data provided in Figure 7 reflects this.

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 to the patient 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 urgent circumstances treatment is necessary for the patient's health or safety or the safety of other people,
- The urgent circumstances treatment is likely to be effective and appropriate in terms of the treatment outcomes referred to in section 6 of the Act, 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 of the Act.

Urgent circumstances treatment may be given for up to 96 hours or until the first of the following occurs:

- The treatment is completed
- An approved medical practitioner stops the treatment
- Until the Assessment Order, Treatment Order or interim Treatment Order ceases or is discharged, or
- 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, and that a copy of the authorisation is given to the patient, the Chief Civil Psychiatrist and to the Tribunal. The approved medical practitioner is also required to ensure that a copy of the authorisation is placed on the patient's clinical record.

Figure 8: Authorisations of Urgent Circumstances Treatment by Region

Area	2014-15	2015-16	2016-17	2017-18	2018-19
North	340	318	375	321	254
North West	162	171	195	160	148
South	342	432	518	477	473
Interstate	10	12	14	12	10
Total	**854**	**933**	**1102**	**970**	**885**
% Children	1.41%	2.25%	4.63%	1.75%	1.81%
% Female (all ages)	41.80%	48.55%	51.63%	49.18%	53.73%

Area	2014-15	2015-16	2016-17	2017-18	2018-19
% Male (all ages)	58.20%	51.45%	48.37%	50.10%	46.27%
% Other (all Ages)	0.00%	0.00%	0.00%	0.72%	0.00%

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 is 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 the 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 accommodation and treatment of long-term voluntary inpatients.

SPECIAL POWERS OF AMBULANCE OFFICERS AND MEDICAL PRACTITIONERS ACTING AS MENTAL HEALTH OFFICERS (POWER OF 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 a patient (or prospective patient) by ambulance under the Act, sedate the patient.

An approved ambulance officer or approved medical practitioner may only sedate a patient if the officer or practitioner reasonably considers it necessary or prudent to do so, having regard to (and in accordance with) any field protocols approved by the Commissioner of Ambulance Services under the *Poisons Act 1971* (Tas).

An approved ambulance officer or approved medical practitioner who exercises the power of sedation under section 212 is to give the Chief Civil Psychiatrist a report of the matter.

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

CHAPTER 4: CHIEF FORENSIC PSYCHIATRIST

The Chief Forensic Psychiatrist has the functions given to him by the Act and by other Acts, and the power to do anything necessary or convenient to be done to perform these functions. This includes matters relating to patient leave and transfers between approved facilities, authorising seclusion or restraint for certain patients, correcting errors in forms that do not affect the form's validity and intervening directly regarding the assessment, treatment and care of forensic patients.

The Chief Forensic Psychiatrist has general overall responsibility, under and to the Minister responsible for administration of the Act, for ensuring that the objects of the Act are met in respect of forensic patients, involuntary patients who are admitted to a secure mental health unit under section 63 of the Act and people who are subject to supervision orders, and for the running of secure mental health units. This responsibility is set out in section 144 of the Act.

The Chief Forensic Psychiatrist also has a significant oversight and review responsibility in respect of decisions made by approved medical practitioners, approved nurses and others in respect of forensic patients.

This responsibility is facilitated through a requirement that information relating to decisions made under the Act by approved medical practitioners and others is provided to the Chief Forensic Psychiatrist as appropriate.

This Chapter reports on the exercise by the Chief Forensic Psychiatrist of the powers and functions given to him by the Act and by other Acts. It also provides information on matters reported to the Chief Forensic Psychiatrist as is required by the Act.

CHIEF FORENSIC PSYCHIATRIST POWERS AND FUNCTIONS

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, a hospital or an institution and transferred to a secure mental health unit under section 36A of the Corrections Act. This may be because the Director determines that it is in best interests of the prisoner or detainee or other people in the prison, hospital or institution 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 best interests of the youth detainee or other people in the detention centre for the detainee to be so removed. 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 a 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 the reasons for the patient's admission are still valid, as well as such other matters that the Chief Forensic Psychiatrist or delegate thinks are relevant, before deciding whether to agree to the request, or refuse the request.

The circumstances in which a forensic patient may ask to be returned 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 9: Requests to Return to Prison/Youth Detention

	2014-15	2015-16	2016-17	2017-18	2018-19
Request to return to prison	1	0	0	0	0
% Female (all ages)	0.00%	0.00%	0.00%	0.00%	0.00%
% Male (all ages)	100.00%	0.00%	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 for 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, and 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 and transferred to a secure institution, an approved hospital, a health service within the meaning of the *Health Complaints Act 1995* (Tas), or premises where such a health service is provided. Section 73 regulates transfers of this kind.

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 10: Forensic Patient transfers to Hospital etc

	2014-15	2015-16	2016-17	2017-18	2018-19
Transfer to hospital	0	174	82	35	32
% Female (all ages)	0.00%	2.30%	1.22%	0.00%	6.25%
% Male (all ages)	100.00%	97.70%	98.78%	100.00%	93.75%

LEAVE OF ABSENCE

The Chief Forensic Psychiatrist or a delegate may:

- Apply to the Mental Health Tribunal, under section 78 of the Act, for leave of absence for a forensic patient who is subject to a restriction order
- Apply to the Mental Health Tribunal, under section 79 of the Act, for an extension of leave or variation of the conditions of leave that has been granted to a forensic patient who is subject to a restriction order under section 78 of the Act
- Cancel leave, under section 79 of the Act, that has been granted to a forensic patient under section 78 of the Act
- Grant leave of absence, under section 82 of the Act, to a forensic patient who is not subject to a restriction order
- Extend, vary or cancel leave, under section 83 of the Act, that has been granted to a forensic patient who is not subject to a restriction order.

The Chief Forensic Psychiatrist or delegate may only apply for leave of absence for a forensic patient who is subject to a restriction order 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, furthering the patient's treatment, and reasons deemed appropriate by the person authorised to grant the leave.

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.

The Chief Forensic Psychiatrist or a delegate may grant leave to a forensic patient who is not subject to a restriction order 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 an application for leave for a forensic patient who is not subject to a restriction order is required to notify the Secretary (Corrections) and others of the application and to consider any submissions received, including from any registered victims, before deciding whether to grant or refuse to grant leave.

Leave for a forensic patient who is not subject to a restriction order 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.

Figure 11: Leave of Absence Granted to Forensic Patients who are not subject to Restriction Orders

	2014-15	2015-16	2016-17	2017-18	2018-19
Leave of Absence	57	38	9	37	4
% Female (all ages)	0.00%	0.00%	0.00%	0.00%	0.00%
% Male (all ages)	100.00%	100.00%	100.00%	100.00%	100.00%

SECLUSION AND RESTRAINT

Forensic patients may be placed in seclusion or under restraint pursuant to the Act in certain, limited circumstances. The circumstances in which a forensic patient may be placed in seclusion or under restraint are set out in sections 94 and 95 of the Act respectively.

A forensic patient may only be placed in seclusion if the patient is in an approved hospital and if:

- The seclusion is authorised as being necessary to facilitate the patient's treatment or general health care, to ensure the patient's health or safety or the safety of others, to prevent the patient from destroying or damaging property, to prevent the patient's escape from lawful custody, to provide for the management, good order or security of a secure mental health unit, to facilitate the patient's lawful transfer to or from another facility, whether in Tasmania or elsewhere, or for a reason sanctioned by Chief Forensic Psychiatrist Standing Orders,
- The 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 any relevant Chief Forensic Psychiatrist Standing Orders or Clinical Guidelines.

For a child patient (a patient who is under the age of 18), seclusion may only be authorised by the Chief Forensic Psychiatrist or a delegate. For other patients, authorisation may be given by the Chief Forensic Psychiatrist or a delegate, or by 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 or general health care, to ensure the patient's health or safety or the safety of others, to prevent the patient from destroying or damaging property, to prevent the patient's escape from lawful custody, to provide for the management, good order or security of a secure mental health unit, to facilitate the patient's lawful transfer to or from another facility, whether in Tasmania or elsewhere, or for a reason sanctioned by Chief Forensic Psychiatrist Standing Orders
- The 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 any relevant 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), the restraint may only be authorised by the Chief Forensic Psychiatrist or a delegate. In other cases, and for other patients, authorisation may be given by the Chief Forensic Psychiatrist or a delegate, or by a medical practitioner or an approved nurse.

Under the Act:

- Mechanical restraint means a device that controls a person's freedom of movement
- Chemical restraint means medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition, and
- Physical restraint means 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 12: Number of seclusion authority forms received by the Chief Forensic Psychiatrist

Hospital	2014-15	2015-16	2016-17	2017-18	2018-19
Seclusion	51	40	20	6	6
% Female (all ages)	9.80%	32.50%	0.00%	0.00%	0.00%
% Male (all ages)	90.20%	67.50%	100.00%	100.00%	100.00%

No new means of restraint were approved by the Chief Forensic Psychiatrist during the 2018 –2019 Financial Year.

CANCELLATION OR SUSPENSION OF PRIVILEGED VISITOR, CALLER OR CORRESPONDENT STATUS

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

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

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

- Section 101 of the Act, which enables the Chief Forensic Psychiatrist, the controlling authority of a secure mental health unit or an authorised person to require a visitor to explain the nature of the person's relationship to any forensic patient in the secure mental health unit and the purpose of the visit, and to provide other relevant information, does not apply to privileged visitors.
- The circumstances in which telephone calls to or from privileged callers may be refused under section 106 are different to the circumstances that apply to telephone calls to or from callers who are not privileged callers.
- The information that a privileged caller may be required to provide under section 106 when making a call to a forensic patient is more limited than the information that a caller who is not a privileged caller may be required to provide.
- The circumstances in which mail to or from privileged correspondents may be refused under section 107 are different to the circumstances that apply to mail to or from correspondents who are not privileged correspondents.
- The ability under section 107 for a forensic patient's mail or email to be opened and read does not extend to mail sent to or from privileged correspondents.

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

For the period 1 July 2018 – 30 June 2019, the Chief Forensic Psychiatrist did not cancel or suspend any individual's privileged visitor, privileged caller or privileged correspondent status.

POWER OF DIRECT INTERVENTION

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

- The use of seclusion or 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, and
- 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 Chief Forensic Psychiatrist's own motion, or on request of the patient or any other person who, in the Chief Forensic Psychiatrist's opinion, has a genuine interest in the patient's health, safety or welfare, and only if the Chief Forensic Psychiatrist has made inquiries into the matter and is satisfied from those inquiries that intervention is essential to the patient's health, safety or welfare.

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

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

The Mental Health Tribunal has jurisdiction to review decisions made by the Chief Forensic Psychiatrist under section 146 of the Act.

For the period 1 July 2018 – 30 June 2019, the Chief Forensic Psychiatrist did not exercise the power of direct intervention.

CORRECTION OF ORDERS WHERE VALIDITY NOT AFFECTED

Under section 224 of the Act, 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 or a delegate.

For the period 1 July 2018 – 30 June 2019, 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 the *Criminal Justice (Mental Impairment) Act*, *Corrections Act*, *Youth Justice Act*, *Criminal Code Act*, *Justices Act*, and the *Sentencing Act*.

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

A main function of the Chief Forensic Psychiatrist under the *Criminal Justice (Mental Impairment) Act*, *Corrections Act*, *Youth Justice Act*, *Criminal Code Act*, *Justices Act*, and the *Sentencing Act* is to provide reports to Courts and other bodies. In most cases report are prepared in practice by delegates of the Chief Forensic Psychiatrist.

Data relating to reports that have been requested in the 2018 – 2019 Financial Year and in previous Financial Years is reported below.

Figure 13: Number of reports requested from the Chief Forensic Psychiatrist

	2014-15	2015-16	2016-17	2017-18	2018-19
Reports Requested	8	10	12	15	16

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 to the patient 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 urgent circumstances treatment is necessary for the patient's health or safety or the safety of other people,
- The urgent circumstances treatment is likely to be effective and appropriate in terms of the treatment outcomes referred to in section 6 of the Act, 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 or until:

- The treatment is completed
- An approved medical practitioner stops the treatment
- The authorisation is set aside by the Tribunal, or
- The patient is discharged from the secure mental health unit,

whichever occurs first.

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

For the period 1 July 2018 – 30 June 2019, there were no authorisations of urgent circumstance treatment for forensic patients.

CHAPTER 5: CHIEF CIVIL PSYCHIATRIST AND CHIEF FORENSIC PSYCHIATRIST

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

The Chief Civil Psychiatrist and the Chief Forensic Psychiatrist each has a role with respect to the admission of involuntary patients who are not prisoners or youth detainees to secure mental health units, as set out below.

ADMISSION OF INVOLUNTARY PATIENTS TO SECURE MENTAL HEALTH UNITS

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

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

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

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

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

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.

Figure 14: Admissions of Involuntary Patients to Secure Mental Health Units

	2014-15	2015-16	2016-17	2017-18	2018-19
Involuntary patient transfer to SMHU	20	16	6	1	3
% Female (all ages)	10.00%	37.50%	50.00%	0.00%	0.00%
% Male (all ages)	90.00%	62.50%	50.00%	100.00%	100.00%

CHAPTER 6: NATIONAL AND TASMANIAN REFORM AGENDA

This Chapter provides an overview of the national and Tasmanian context in which the Act operates and the significant work that the incumbent to the Chief Civil Psychiatrist and Chief Forensic Psychiatrist roles has undertaken within the broader mental health sector in Tasmania during the 2018 – 2019 Financial Year.

NATIONAL CONTEXT

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

FUNDING AND SERVICE DELIVERY

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

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

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

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

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

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

NATIONAL REFORM AGENDA

Mental health services in Australia have been shaped by the National Mental Health Policy and its revision in 2008, together with a series of national mental health plans. Implementation of these plans has seen a shift from institutionalised care to supported care in the community and more recently a stronger focus on person centred and recovery orientated approaches, and mental health promotion, prevention and early intervention.

The *Fifth National Mental Health and Suicide Prevention Plan* (the Fifth Plan) and accompanying Implementation Plan were endorsed by the Council of Australian Governments (COAG) in August 2017.

The Fifth Plan seeks to establish a national approach for collaborative government effort from 2017 - 2022 across the following targeted priority areas:

- Achieving integrated regional planning and service delivery
- Effective suicide prevention
- Coordinated treatment and supports for people with severe and complex mental illness
- Improving Aboriginal and Torres Strait Islander mental health and suicide prevention
- Improving the physical health of people living with mental illness and reducing early mortality
- Reducing stigma and discrimination
- Making safety and quality central to mental health service delivery
- Ensuring that the enablers of effective system performance and system improvement are in place.

Governance arrangements for implementation of the Fifth Plan feature the following:

- A Mental Health Principal Committee (MHPC)
- A Safety and Quality Partnership Standing Committee (SQPSC)
- A Mental Health Information Strategy Standing Committee (MHISSC)
- A Mental Health Expert Reference Panel (MHERP)
- A Suicide Prevention Project Reference Group (SPPRG)
- An Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group (ATSIMHSPPRG), and
- A Fifth Plan Technical Advisory Group (FPTAG).

MHPC

The MHPC has a critical role in leading and coordinating the implementation of Action Items associated with each of the Priority Areas identified in the Fifth Plan. MHPC is a subcommittee of the Australian Health Ministers Advisory Council (AHMAC) and is responsible for developing and implementing a shared National Mental Health and Suicide Plan in addition to advising AHMAC on mental health and drug service issues of national significance.

The incumbent to the Chief Civil Psychiatrist and Chief Forensic Psychiatrist roles is Tasmania's representative on the MHPC.

SQPSC

The SQPSC provides expert technical advice and recommendations to the MHPC on the development of national policy and strategic directions for safety and quality in mental health taking into consideration matters including the Fifth Plan and other health initiatives. The SQPSC also responds, through the provision of advice to the MHPC, on emerging issues of concern and related safety and quality issues.

The incumbent to the Chief Civil Psychiatrist and Chief Forensic Psychiatrist roles is Tasmania's representative on the SQPSC.

Mutual Recognition of Mental Health Orders

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

Action 26 of the Fifth Plan requires Governments to improve consistency across jurisdictions in mental health legislation with a view to ensuring seamless and safe care for consumers, particularly consumers who move between states and territories. Queensland and Tasmania were identified as project leads for Action 26 of the Fifth Plan, jointly developing a paper exploring options for how best to deal with the transfer and return of people subject to mental health orders from one jurisdiction to another. The paper was developed during the 2018 – 2019 Financial Year and is expected to be considered by Ministers later in 2019.

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

The incumbent to the Chief Civil Psychiatrist and Chief Forensic Psychiatrist roles has led this work for Tasmania.

MHISSC

The MHISSC is a Standing Committee of the MHPC. Its role is to provide expert technical advice and, where required, to recommend policy for consideration by the MHPC.

MHISSC brings together jurisdictional mental health data representatives and key stakeholders including consumers, carers, clinicians, peak bodies and key organisations. It provides a collaborative

forum for the development and implementation of national initiatives in mental health information and provides expert technical advice and recommendations for the information requirements of the *National Mental Health Strategy*.

Tasmania is represented on the MHISSC by staff from the Mental Health, Alcohol and Drug Directorate.

MHERP

The MHERP provides expert advice to AHMAC, through the MHPC, on the implementation of the Fifth Plan. It also takes matters of importance in mental health and suicide prevention to the MHPC for consideration and provides advice to the MHPC on renewal of the National Mental Health Policy.

The incumbent to the Chief Civil Psychiatrist and Chief Forensic Psychiatrist role was appointed as Chair of the MHERP in September 2018.

Participation in the work of the MHPC, SQPSC and MHERP, along with subcommittees of these groups, enables the incumbent to the Chief Psychiatrist roles 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.

SPPRG

The SPPRG is a subcommittee of the MHPC. It is responsible for reporting on priorities for planning and investment in suicide prevention and for development of the National Suicide Prevention Strategy under Action 4 of the Fifth Plan.

The SPPRG comprises representatives from governments, national stakeholders, large service providers, academics and people with a lived experience of suicide.

The incumbent to the Chief Civil Psychiatrist and Chief Forensic Psychiatrist roles is Tasmania's representative on the SPPRG.

ATSIMHSPPRG

The ATSIMHSPPRG is also a subcommittee of the MHPC. It is responsible for reporting on priorities for planning and investment in mental health care and suicide prevention in Aboriginal and Torres Strait Islander communities, and for working with the SPPRG on the development of the National Suicide Prevention Strategy.

Tasmania is represented on the ATSIMHSPPRG by staff from the Mental Health, Alcohol and Drug Directorate within the Department of Health.

FPTAG

The FPTAG supports the National Mental Health Commission in monitoring and reporting to the Council of Australian Government Health Council on implementation of the Fifth Plan and performance against identified indicators by providing advice as required.

The incumbent to the Chief Civil Psychiatrist and Chief Forensic Psychiatrist roles is Tasmania's representative on the FPTAG.

STATE CONTEXT

FUNDING AND SERVICE DELIVERY

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

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

- 24-hour acute inpatient services located at three public hospitals (the Royal Hobart Hospital, the Launceston General Hospital and the North West Regional Hospital - Burnie Campus)
- a 24-hour older persons acute/sub-acute inpatient unit located in the South providing services to people across the state (the Roy Fagan Centre)
- a 24-hour step up/step down facility located in the South (Mistral Place)
- 24-hour specialist extended treatment units located in the South and providing services to people across the state (the Millbrook Rise Centre and Tolosa Street)
- child and adolescent, older persons and adult community mental health services that operate throughout the state
- adult community mental health teams that provide crisis, assessment and treatment and triage services
- a 24-hour statewide helpline and triage service – the Mental Health Services Helpline, and
- community and inpatient care for people with a mental illness who are involved with, or who are a risk of involvement with, the justice system (community forensic mental health services teams and the Wilfred Lopes Centre).

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

The Tasmanian Government also funds a range of community-based organisations to provide services including:

- psychosocial support services
- individual packages of care
- residential rehabilitation
- community-based recovery and rehabilitation

- peer support groups
- prevention and brief intervention services, and
- advocacy and peak body representation for consumers, carers and service providers.

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

STATE REFORM AGENDA

Rethink Mental Health Long-Term Plan

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 *Rethink* Mental Health Plan is available online here (www.dhhs.tas.gov.au/mentalhealth/rethink_mental_health_project).

The incumbent to the Chief Civil Psychiatrist and Chief Forensic Psychiatrist roles is Chair of the *Rethink* Mental Health Plan Implementation Steering Committee.

Mental Health Integration Taskforce

The Mental Health Integration Taskforce was established in March 2018 to consider how mental health care should best be delivered to people in Southern Tasmania. The process involved considering of a range of national and international reforms, initiatives and evaluations and key strategic planning processes and the views of clinicians for inpatient and community mental health services, GPs, consumer peak bodies, unions, and people with lived experience of the mental health system in Southern Tasmania.

These deliberations led the Taskforce to consider integration in vertical and horizontal dimensions, reflective of the complex interactions that occur within any mental health system and within other

human service delivery systems and representing a useful framework for how best to reform the service system.

The Taskforce noted slow progress towards achieving of the commitments made through Rethink to developing an integration mental health service. The Taskforce also considered reasons for this and how obstacles to integration could be removed and completed a report in April 2019 containing 21 recommendations for achieving lasting system change. The report was released in July 2019.

Amongst other key reforms the Taskforce recommended establishing a 24-hour integrated service hub that consists of a range of collocated social services, disability support services, peer-operated services and clinical services, built around ensuring the recovery concept and supported by sub-acute residential services.

The Taskforce's Report and Recommendations, and the Government's Response, can be found online here (www.dhhs.tas.gov.au/news/2019/mental_health_integration_taskforce_report).

The incumbent to the Chief Civil Psychiatrist and Chief Forensic Psychiatrist roles is Chair of the Mental Health Integration Taskforce.

Prisoner Mental Health Care Taskforce

The Prisoner Mental Health Care Taskforce was established in September 2018 to examine processes and procedures relating to prisoner mental health care, and to provide advice to the Minister for Corrections and the Minister for Health, through the Secretary of the Department of Justice and the Secretary of the Department of Health, on ways in which the delivery of mental health services to prisoners and people who are remanded can be improved.

The Taskforce produced a Final Report in March 2019. The Report makes 19 recommendations to improve the delivery of mental health services to prisoners and people who are remanded and as at 30 June 2019, several of the Report's recommendations were in the process of being implemented.

The Prisoner Mental Health Care Taskforce was co-chaired by the incumbent to the Chief Civil Psychiatrist and Chief Forensic Psychiatrist role, and the Director of Prisons.

The Final Report is not publicly available.

Connecting with People

The Connecting with People (CwP) approach to suicide mitigation was developed in the United Kingdom by 4 Mental Health Limited.

The CwP training approach is designed to improve the response given to people in distress or at risk of suicide. CwP is informed by evidence-based principles, lived experience and clinical expertise and aims to increase the use of a compassionate approach, reduce stigma and enhance participants' ability to compassionately respond to someone who has suicidal thoughts or following self-harm.

Underpinning CwP is a philosophy that suicide is not inevitable. CwP offers a new narrative that moves away from characterising, quantifying and managing risk, towards placing greater focus upon compassion, safeguarding and co-designed safety plans. CwP offers a clinical governance framework and the appropriate tools (including the SAFE-Tool) to build knowledge and understanding, and confidence to support people in suicidal distress.

CwP offers a common language to describe the nature and intent of suicidal thoughts, enabling greater clarity, accuracy and consistency between clinicians, consumers, families, carers and organisations, as well as improving the quality of documentation.

The CwP approach has been adapted for delivery in Australia and the first Tasmanian cohort of 17 trainers was trained in the CwP approach by a master trainer from the United Kingdom with support from associate trainers from the University of South Australia in June 2018. A further 13 trainers received accreditation in May 2019.

CwP training is being delivered to priority workforces identified in the Suicide Prevention Workforce Development and Training Plan for Tasmania 2016-2020. Rollout of the approach is being led by the incumbent to the Chief Civil Psychiatrist and Chief Forensic Psychiatrist roles, who is himself a master trainer.

Suicide Prevention Initiatives

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:

- 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
- Empower and support young people, families and communities to respond to suicidal behaviours and the impact of suicidal behaviours
- Implement public health approaches to reduce suicidal behaviour and increase community literacy about suicide and suicide prevention
- Ensure effective implementation, monitoring and evaluation of the Strategy
- 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 reducing youth suicide, suicidal behaviour and the impact upon young people in Tasmania. This Plan identifies five priority areas:

- Start early by focusing on the resilience, mental health and well-being of children, parents and families
- Empower young people, families and wider community networks to talk about suicide and respond to young people at risk of suicide
- Build the capacity of schools, and other educational settings to support young people who may be at risk of suicide or impacted by suicide

- Develop the capacity of the service system to support young people experiencing suicidal thoughts and behaviours
- 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:

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

The incumbent to the Chief Civil Psychiatrist and Chief Forensic Psychiatrist roles 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. He is Chair of the Tasmanian Suicide Prevention Committee (TSPC), a whole of government and community committee that oversees the implementation of the Tasmanian Government's suicide prevention policy framework.

The incumbent 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

TERP Forum

In November 2018 Tasmania hosted the 12th Towards Eliminating Restrictive Practices (TERP) National Forum. Dr Aaron Groves the incumbent to the Chief Civil Psychiatrist and Chief Forensic Psychiatrist roles was the Forum convenor.

The program was organised around the theme How far can we go? and provided an opportunity for clinicians, policy makers, researchers and people with lived experience of mental illness from across Australia to share innovative ideas and be informed about evidence-based policy and service delivery directions.

The TERP Forum is hosted every one-to-two years around Australia to contribute to the aim of identifying, avoiding and reducing harm across all environments in which care for people with mental illness is provided. The 2018 Forum provided two days of discussion about eliminating the use of restrictive practices in mental health care settings, asking speakers and participants to reflect on patterns of change in the use of restrictive practices over the past 10-15 years and identify what's required to keep moving towards elimination.

The Forum is generally hosted by a nominated jurisdiction in conjunction with the SQPSC, with funding provided through the MHPC with support from the National Mental Health Commission.

Statewide Restrictive Interventions Review Panel

The Statewide Restrictive Interventions Review Panel meets on a quarterly basis and examines all incidents of restrictive practices that have been reported to the Panel in the intervening period. 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.

The incumbent to the Chief Civil Psychiatrist and Chief Forensic Psychiatrist roles is Chair of the Statewide Restrictive Interventions Review Panel.

Figure 14: Tasmanian Seclusion Events per 1 000 Bed Days by Inpatient Unit for the Period 2013 - 14 to 2018-19

Unit	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19
Northside	16.01	9.2	14.3	4.3	5	5.7
Spencer Clinic	5.87	5.7	4.8	5.6	5.4	5.8
Department of Psychiatry	23.6	15.3	17.8	17.9	9.5	13.6
Wilfred Lopes Centre	4.86	5.8	10	7	3	3.7
TOTAL	**15.2**	**10.1**	**13.1**	**10.2**	**6.4**	**8.5**

APPENDIX 1: APPROVED FORMS

The forms approved by the Chief Civil Psychiatrist since the Act's commencement in February 2014 and that were in place on 30 June 2019 are as follows:

- Decision-making capacity (CCP Approved Forms 2A and 2B)
- Protective Custody (CCP Approved Form 4)
- Assessment Orders (CCP Approved Form 6)
- Treatment Plans (CCP Approved Form 7)
- Urgent Circumstances Treatment (Involuntary Patients) (CCP Approved Form 8)
- Seclusion (Involuntary Patients) (CCP Approved Form 9)
- Restraint (Involuntary Patients) (CCP Approved Form 10)
- Leave (Involuntary Patients) (CCP Approved Forms 11, 12A, 12B and 12C)
- Involuntary Patient Transfer Between Hospitals (CCP Approved Form 13)
- Admission of an involuntary patient to hospital following failure to comply with a Treatment Order (CCP Approved Form 22)
- Admission of an involuntary patient to hospital to prevent possible harm (CCP Approved Form 23)
- Involuntary Patient Escort to Hospital (CCP Approved Form 24).

The forms approved by the Chief Forensic Psychiatrist since the Act's commencement in February 2014 and that were in place on 30 June 2019 are as follows:

- Urgent Circumstances Treatment (Forensic Patients) (CFP Approved Form 8)
- Seclusion (Forensic Patients) (CFP Approved Form 9)
- Restraint (Forensic Patients) (CFP Approved Form 10)
- Leave (Forensic Patients) (CFP Approved Forms 12A, 12B and 12C)
- Search and Seizure (CFP Approved Form 16)
- Forensic Patient Transfer to Hospital (CFP Approved Form 17)
- Cancellation or Suspension of Visits (CFP Approved Form 18)
- Forensic Patient Request to Return to Prison/Youth Detention (CFP Approved Forms 20A and 20B).

APPENDIX 2: STANDING ORDERS AND CLINICAL GUIDELINES

The following Standing Orders issued by the Chief Civil Psychiatrist were in place as at 30 June 2019:

- Chief Civil Psychiatrist Standing Order 8 - Urgent Circumstances Treatment
- Chief Civil Psychiatrist Standing Order 9 – Seclusion
- Chief Civil Psychiatrist Standing Order 10 - Chemical Restraint
- Chief Civil Psychiatrist Standing Order 10A - Mechanical Restraint and Physical Restraint

The following Standing Orders issued by the Chief Forensic Psychiatrist were in place as at 30 June 2019:

- Chief Forensic Psychiatrist Standing Order 8 - Urgent Circumstances Treatment
- Chief Forensic Psychiatrist Standing Order 9 - Seclusion
- Chief Forensic Psychiatrist Standing Order 10 - Chemical Restraint
- Chief Forensic Psychiatrist Standing Order 10A - Mechanical Restraint and Physical Restraint
- Chief Forensic Psychiatrist Standing Order 15 - Visitor Identification
- Chief Forensic Psychiatrist Standing Order 16 – Entry Screen and Search
- Chief Forensic Psychiatrist Standing Order 17 – Unauthorised Items
- Chief Forensic Psychiatrist Standing Order 21 – Use of Force.

The Chief Civil Psychiatrist and Chief Forensic Psychiatrist have issued one joint Standing Order - Standing Order 19 – Involuntary Patient Admission to Secure Mental Health Unit.

The following Clinical Guidelines issued by the Chief Civil Psychiatrist were in place as at 30 June 2019:

- Chief Civil Psychiatrist Clinical Guideline 1 – Meaning of Mental Illness
- Chief Civil Psychiatrist Clinical Guideline 7 – Off-Label Use of Medications
- Chief Civil Psychiatrist Clinical Guideline 8 - Urgent Circumstances Treatment
- Chief Civil Psychiatrist Clinical Guideline 9 – Seclusion
- Chief Civil Psychiatrist Clinical Guideline 10 – Chemical Restraint
- Chief Civil Psychiatrist Clinical Guideline 10A - Mechanical Restraint and Physical Restraint.

The following Clinical Guidelines issued by the Chief Forensic Psychiatrist were in place as at 30 June 2019:

- Chief Forensic Psychiatrist Clinical Guideline 8 – Urgent Circumstances Treatment
- Chief Forensic Psychiatrist Clinical Guideline 9 – Seclusion
- Chief Forensic Psychiatrist Clinical Guideline 10 – Chemical Restraint
- Chief Forensic Psychiatrist Clinical Guideline 10A – Mechanical Restraint and Physical Restraint.

The Chief Civil Psychiatrist and Chief Forensic Psychiatrist have issued several joint Clinical Guidelines, as follows:

- Chief Civil Psychiatrist and Chief Forensic Psychiatrist Clinical Guideline 2 – Capacity
- Chief Civil Psychiatrist and Chief Forensic Psychiatrist Clinical Guideline 3 – Representative and Support Person.

APPENDIX 3: CHIEF CIVIL PSYCHIATRIST - POWERS AND FUNCTIONS UNDER OTHER ACTS

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

- Notifying the Attorney General of a defendant's subsequent fitness to stand trial under section 29 of the *Criminal Justice (Mental Impairment) Act*
- Receiving notification that no further proceedings are to be taken against a defendant from the Attorney-General under section 29 of the *Criminal Justice (Mental Impairment) Act*
- Reporting to the Court under section 75 of the *Sentencing Act*.

APPENDIX 4: CHIEF FORENSIC PSYCHIATRIST - POWERS AND FUNCTIONS UNDER OTHER ACTS

The Chief Forensic Psychiatrist has powers and functions under the *Criminal Justice (Mental Impairment) Act,* the *Sentencing Act*, the *Criminal Code Act*, the *Corrections Act* and the *Youth Justice Act.*

The Chief Forensic Psychiatrists under the *Criminal Justice (Mental Impairment) Act* include:

- Applying to the Supreme Court for discharge of a restriction order under section 26
- Preparing and submitting a report to the Court under section 26
- Notifying the Attorney General of a defendant's subsequent fitness to stand trial under section 29
- Receiving notification that no further proceedings are to be taken against a defendant from the Attorney-General under section 29
- Supervising people on supervision orders under section 29A
- Notifying the Mental Health Tribunal of a patient's objection to taking medication or to the administration of medical treatment under section 29A
- Applying to the Court for variation or revocation of a supervision order under section 30
- Providing a report to the Court under section 30
- Apprehending a person under section 31
- Receiving notification that a person has been apprehended under section 31
- Authorising the admission to a secure mental health unit of a defendant for a further period under section 31
- Reporting to the Court under section 35
- Reporting to the Court under section 39
- Reporting to the Court under section 39A, and
- Authorising persons under section 41A.

The Chief Forensic Psychiatrist's functions under the *Sentencing Act* are to provide advice to the Court under section 72 and to report to the Court under section 75.

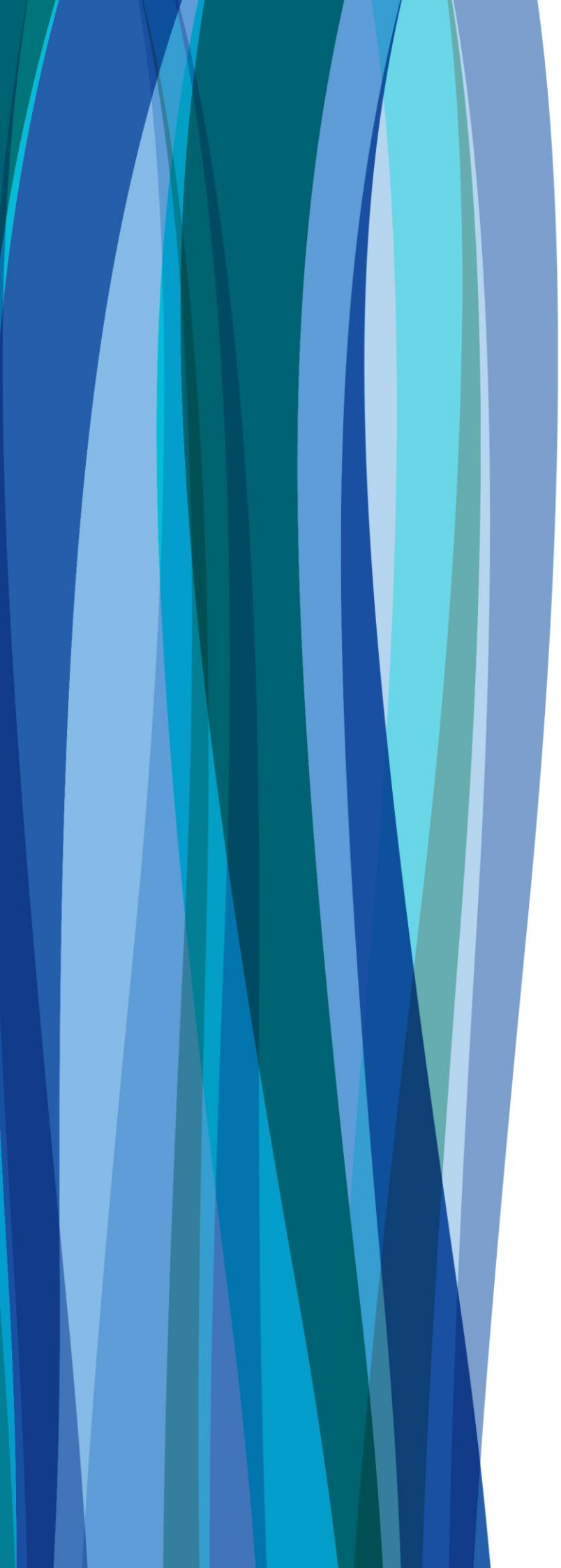
The Chief Forensic Psychiatrist's functions under the *Criminal Code Act* are to report to the Court under section 348 and to apply to the Court for revocation of a restriction order under section 348.

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

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

- Reporting to the Court under section 105
- Reporting to the Court under section 134A

- Having input to the decision to admit a youth detainee to the secure mental health unit under section 134A, and
- Requiring the Secretary, Youth Justice to remove a youth detainee from the secure mental health unit under section 134A.



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