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

OUTCOMES REPORT

Office of the Chief Psychiatrist
Department of Health

Tasmanian Government

Date: June 2020

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For further information, please contact:

Office of the Chief Psychiatrist
GPO Box 125
HOBART TAS 7001

Foreword

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

When the Act commenced on 17 February 2014, it represented a significant reform in how people who live with mental illness are assessed and treated.

The Tasmanian Government at the time included a requirement that the Minister for Mental Health and Wellbeing review the Act's operation after six years of it commencing.

The Act's operation has now been reviewed and I am pleased as Minister for Mental Health and Wellbeing, to table this Report on the outcome of the review.

The review confirms that the Act has had a positive impact on how people who live with mental illness are assessed and treated in Tasmania, and also identifies some issues with aspects of the Act's operation.

The Report describes the review process, and the outcomes of that process. It also identifies ways in which the issues identified through the review and noted in this Report can be addressed.

I sincerely thank the people and organisations who have contributed to the review, including members of the Steering Committee and each of the Reference Groups established to guide and support the review, and the many individuals who have taken the time to document their experiences of the Act and provide a submission to be considered through the review process.

The review was completed shortly before the Director of Public Health declared a public health emergency relating to coronavirus disease 2019 (COVID-19) in Tasmania. The health and economic effects of this disease are likely to be long lasting, and I acknowledge this may impact on the steps that can be taken to implement the Government's response to this report in the short and potentially medium term. I look forward to working with stakeholders to improve the Act's operation in due course.

The Hon Jeremy Rockliff MP
Minister for Mental Health and Wellbeing
June 2020

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Acknowledgements

This Outcomes Report and the Consultation Document that preceded it were prepared by the Office of the Chief Psychiatrist with input from members of a Project Steering Committee.

The Outcomes Report and Consultation Document can be accessed from www.health.tas.gov.au/mhactreview or sent to you by the Office of the Chief Psychiatrist.

The Office of the Chief Psychiatrist can be contacted on:

Email: chief.psychiatrist@health.tas.gov.au

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

Phone: 03 6166 0778

Executive Summary

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

This Outcomes Report provides background to the Act and to the review. It outlines the Act's provisions and explains the review process. It also details feedback received from respondents on the Act's operation and summarises the feedback in 29 review outcomes. Lastly the Report suggests legislative and other responses that will be taken in the coming months to address the review outcomes.

The review has confirmed that the Act has had a generally positive impact on how people who live with mental illness are assessed and treated in Tasmania.

Feedback about the Act's positive impact is not uniform, and the review has suggested some issues with the Act's operation. These range from issues with the way the Act is understood to problems with its provisions. Reasons given for this were varied and included broader issues affecting the health system in Tasmania, lack of a clear or shared understanding about the Act's requirements, insufficient resourcing and lack of clarity in some of the Act's provisions.

The Review Outcomes, and the Government's Response to those Outcomes, are referred to throughout the document. The Review Outcomes are extracted at Appendix A while the Government's Responses to those Outcomes are extracted at Appendix B for ease of reading.

Language Used in This Document

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

A glossary of terms used frequently in this document is included at Appendix C.

1. Introduction

1.1 Background to the Act

The *Mental Health Act 2013* (Tas) (the Act) provides for the assessment and treatment of mental illness. It commenced on 17 February 2014.

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

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

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

1.2 Background to the Review

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

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

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

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

The requirement for the Act to be reviewed was included in light of these fundamental changes.

Under section 229 of the Act, the Minister for Mental Health and Wellbeing is to review the operation of the Act, and complete the review, within six years after the Act's commencement.

Under section 229 of the Act, the Minister is also to cause a Report on the outcome of the review to be tabled in each House of Parliament within ten sitting-days of each House after the review is completed.

1.3 Conduct of the Review

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

- a roundtable discussion with key stakeholders within the Tasmanian Department of Justice including the President of the Mental Health Tribunal (MHT), the Deputy Secretary Administration of Justice, the Ombudsman, the Registrar of the Guardianship and Administration Board, the Public Guardian, the Anti-Discrimination Commissioner, the Tasmania Prison Service and staff of the Department of Justice's Strategic Policy and Legislation Unit
- discussions with other stakeholders including the then Chief Civil Psychiatrist and Chief Forensic Psychiatrist, Tasmanian Health Service and Alcohol and Drug Services staff and staff of the Mental Health, Alcohol and Drug Directorate and Legal Services Units within the then Department of Health and Human Services, and
- discussions with other stakeholders including the Tasmania Law Reform Institute (TLRI) and the Tasmania Police Mental Health Liaison Officer.

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

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

A Steering Committee and four Reference Groups were established in July 2019 with each group meeting on several occasions throughout the second half of 2019.

More information about the Steering Committee and Reference Group membership is outlined at Appendix D.

A Consultation Document was provided to members of the Steering Committee and Reference Groups on 3 September 2019 and published on the Department of Health's website (www.health.tas.gov.au/mhactreview) on 9 September 2019.

The Consultation Document invited respondents to provide feedback on the issues raised and the questions asked in the Consultation Document by answering any, or all, of the questions asked.

The questions asked in the Consultation Document are extracted at Appendix C.

Respondents were invited to:

- complete a Response Template. Respondents were given the option of completing the Template electronically or printing the document and completing it manually with completed responses emailed or posted to the Office of the Chief Psychiatrist. Respondents were invited to access the Template from the Department of Health's website (www.health.tas.gov.au/mhactreview)
- make a written submission. Respondents were invited to write on any, or all, aspects of the Act's operation and were given the option of emailing or posting their submission to the Office of the Chief Psychiatrist using the contact details provided, or
- provide feedback through Flourish Mental Health Action In Our Hands Inc (Flourish), Advocacy Tasmania, Mental Health Families and Friends Tasmania Inc. (formerly Mental Health Carers Tasmania), Carers Tasmania, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Tasmanian Branch or the Australian College of Mental Health Nurses (ACMHN) Tasmanian Branch. Contact details were provided in the Consultation Document for each of the

organisations through which feedback could be provided. A copy of the information provided is extracted at Appendix F.

Details of the review and how to access the Consultation Document and Response Template were included as a Top Story on the Department of Health's homepage and as a news item in the Department of Health's regular weekly newsletter, *News and Announcements*.

As well as the Consultation Document, the Office of the Chief Psychiatrist produced a short video message featuring Dr Groves and advising members of the community about the review and how to contribute to it. The video message was placed on the Department of Health's YouTube channel and linked to from the Department of Health's website. The video message was also used by Carers Tasmania to introduce the review to people who attended consultation sessions.

Web analytics suggest that from 9 September to 5 December 2019:

- More than 600 people accessed www.health.tas.gov.au/mhactreview.
- More than 140 people viewed the News item on the Department of Health's homepage.
- The video message had been viewed more than 190 times.

Specific feedback on the Act's operation was also sought from relevant Agencies including the Department of Communities Tasmania, the Department of Premier and Cabinet, the Department of Justice, the Department of Education, and the Department of Police, Fire and Emergency Management.

The consultation period for the review spanned nine weeks, from Monday 9 September 2019 to Friday 8 November 2019. A short extension (until close of business Monday 11 November 2019) was provided to a small number of stakeholders on request. In that time a total of 33 written submission were received.

According to their Terms of Reference, members of the Carer Reference Group, Consumer Reference Group and Clinical Reference Group were responsible for identifying issues with the Act's operation and for conveying these to the relevant Reference Group within required timeframes. In this context, members of the Reference Groups were invited to provide general views on the Act's operation through meetings that occurred in the consultation period. Members of the Statutory Reference Group were additionally invited to provide specific feedback on the Act's operation using the Consultation Document as a guide at a specially convened Reference Group meeting that took place on 31 October 2019.

Consultation in respect of the Act's operation was also facilitated by Reference Group members during the consultation period, as follows:

- Carers Tasmania informed its members and people who have access the services provided by Carers Tasmania about the review of the Act's operation via email and via Carers Tasmania's quarterly magazine *Carers News*. Carers Tasmania also engaged with carers in Tasmania via a series of consultations held in Hobart, Launceston and Devonport. The consultations were promoted through Carers Tasmania's Facebook page and to current consumers of Statewide Mental Health Services with a total of 20 carers attending. A follow up email was sent to those carers who registered but did not attend consultation sessions with information about how to contribute to the review process. Carers Tasmania also had several one-on-one conversations with carers and with members of Carers Tasmania's Mental Health Carers Reference Group. Feedback received through these processes informed Carers Tasmania's submission to the review.
- Mental Health Families and Friends Tasmania Inc. disseminated information about the review and how to contribute to it to its members and posted information about the review on its Facebook page.

- Flourish sought feedback on the Act's operation through its Southern, Northern and North Western Local Action Groups as follows:
    - The Southern Flourish Local Action Group (Southern FLAG) expanded upon the questions asked in the Consultation Document and Response Template to produce a survey for consumers. 29 people responded to the survey, with responses received informing the Southern FLAG's submission to the review.
    - The Northern Flourish Local Action Group (Northern FLAG) sought feedback on the questions asked in the Response Template from its membership, with responses received informing the Northern FLAG's submission to the review.
    - The North Western Flourish Local Action Group (North Western FLAG) considered the document but did not provide a submission.

  Flourish also published information about the review on its Facebook page.
- Advocacy Tasmania provided information to clients about the review, including the right to advocacy support to make a submission and alternate ways to engage with the process, such as through Flourish or directly to the Office of the Chief Psychiatrist. Some advocates went through the Consultation Document with clients to help them to understand it and to make a submission.
- The ACMHN Tasmanian Branch consulted with members living in Tasmania on the review to inform the Branch's submission to the review.
- The RANZCP Tasmanian Branch called for submissions from psychiatrists working in inpatient and community services, in private and medico-legal areas for personal observations on the operation of the Act. The opinion of all registrars working within the Tasmanian Health Service was also sought. 18 psychiatrists and registrars responded to the call for submissions and these responses informed the Branch's submission.
- The Tasmanian Health Service sought feedback from nursing and other clinical staff in each of the regions on the Act's operation and forwarded feedback received from individuals and groups to the Office of the Chief Psychiatrist for consideration.

The contributions of each of these groups in facilitating consultation on the Act's operation is acknowledged, and deeply appreciated.

1.4 About this Outcomes Report

This Outcomes Report has several parts:

- Part 1 (this Part) introduces the Act and provides background to Act and to the review.
- Part 2 provides an overview of the policy and legal context in which the Act operates.
- Part 3 provides an overview of the Act's provisions.
- Part 4 provides information about the Act's objects and the Mental Health Service Delivery Principles, describes the feedback received on the operation of relevant provisions of the Act and identifies outcomes associated with these aspects of the Act's operation, and the Government's response to those outcomes.
- Part 5 provides information about key concepts underpinning the Act's operation including Decision-Making Capacity and the Meaning of Mental Illness, describes the feedback received on the operation of relevant provisions of the Act and identifies outcomes associated with these aspects of the Act's operation, and the Government's response to those outcomes.

- Part 6 describes the assessment framework established by the Act and outlines the operation of provisions for Assessment Orders, describes the feedback received on the operation of relevant provisions of the Act and identifies outcomes associated with these aspects of the Act's operation, and the Government's response to those outcomes.
- Part 7 describes the treatment framework established by the Act and outlines the operation of provisions for urgent circumstances treatment, Treatment Orders, treatment plans and special psychiatric treatment, describes the feedback received on the operation of relevant provisions of the Act and identifies outcomes associated with these aspects of the Act's operation, and the Government's response to those outcomes.
- Part 8 talks about how the Act regulates assessment and treatment for children and the operation of provisions for that purpose, describes the feedback received on the operation of relevant provisions of the Act and identifies outcomes associated with these aspects of the Act's operation, and the Government's response to those outcomes.
- Part 9 provides information about provisions for involuntary patient transfers and leave, and for involuntary patient rights, describes the feedback received on the operation of relevant provisions of the Act and identifies outcomes associated with these aspects of the Act's operation, and the Government's response to those outcomes.
- Part 10 refers to forensic patients and talks about the operation of the Act's provisions for forensic patient admissions, discharges and periods of detention; forensic patient movements and forensic patient leave; forensic patient treatment; forensic patient management and forensic patient rights. Part 9 also describes the feedback received on the operation of relevant provisions of the Act and identifies outcomes associated with these aspects of the Act's operation, and the Government's response to those outcomes.
- Part 11 applies to the operation of provisions for seclusion and restraint. It describes these provisions and the feedback received on the operation of relevant provisions of the Act and identifies outcomes associated with these aspects of the Act's operation, and the Government's response to those outcomes.
- Part 12 provides information about the protective custody and custody and escort provisions of the Act, describes the feedback received on the operation of relevant provisions of the Act and identifies outcomes associated with these aspects of the Act's operation, and the Government's response to those outcomes.
- Part 13 describes provisions for the approval of facilities and personnel and talks about the operation of those provisions, describes the feedback received on the operation of relevant provisions of the Act and identifies outcomes associated with these aspects of the Act's operation, and the Government's response to those outcomes.
- Part 14 talks about the operation of provisions for information management, describes the feedback received on the operation of relevant provisions of the Act and identifies outcomes associated with these aspects of the Act's operation and the Government's response to those outcomes.
- Part 15 provides information about the MHT and provisions for its operation including for the Tribunal's establishment, powers and functions; and its proceedings. Part 15 also describes the feedback received on the operation of relevant provisions of the Act and identifies outcomes associated with these aspects of the Act's operation, and the Government's response to those outcomes.

- Part 16 provides information about the operation of provisions for the Principal Official Visitor, and Official Visitors. Part 16 also describes the feedback received on the operation of relevant provisions of the Act and identifies outcomes associated with these aspects of the Act's operation, and the Government's response to those outcomes.
- Part 17 provides information about the operation of provisions for the Chief Civil Psychiatrist and Chief Forensic Psychiatrist. Part 17 also describes the feedback received on the operation of relevant provisions of the Act and identifies outcomes associated with these aspects of the Act's operation, and the Government's response to those outcomes.
- Part 18 provides information about provisions for interstate transfer agreements and interstate control agreements and work that is occurring nationally to develop model provisions and a different mode of operation. Part 18 also describes the feedback received on the operation of relevant provisions of the Act and identifies outcomes associated with these aspects of the Act's operation, and the Government's response to those outcomes.
- Part 19 provides information about provisions for the rights and responsibilities of carers and family members; offences and immunities, remote medical procedures, powers of sedation, conflicts of interest and the correction of orders; and other aspects of the Act's operation not covered in other Parts of the Outcomes Report. Part 19 also describes the feedback received on the operation of relevant provisions of the Act and identifies outcomes associated with these aspects of the Act's operation, and the Government's response to those outcomes.
- Appendix A (Review Outcomes) provides a summary of the Review Outcomes.
- Appendix B (Government Response to Review Outcomes) provides a summary of the Government's Response to the Review Outcomes.
- Appendix C (Glossary of Terms) defines key terms used in the Act and in this Outcomes Report.
- Appendix D (Governance Arrangements) provides information about Steering Committee and Reference Group membership.
- Appendix E (Questions Asked) outlines the questions asked in the Consultation Document.
- Appendix F (Representative Bodies or Groups) identifies the organisations through which people were invited to provide feedback on the Act's operation.
- Appendix G (Mental Health Service Delivery Principles) outlines the mental health service delivery principles set out in Schedule 2 to the Act.
- Appendix H (Meaning of Mental Illness) outlines the meaning of mental illness provided in the Act.
- Appendix I (Involuntary Patient Rights) lists the rights that involuntary patients have under the Act.
- Appendix J (Forensic Patient Rights) lists the rights that forensic patients have under the Act.
- Appendix K (Record Keeping Requirements) provides information on the record keeping requirements that apply under the Act.
- Appendix L (Mental Health Tribunal Review Functions) lists the review functions that the MHT has under the Act.
- Appendix M (Chief Psychiatrist Approved Forms) identifies the forms that have been approved by the Chief Civil Psychiatrist and the Chief Forensic Psychiatrist for use under the Act.

2. Policy and Legal 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[1].

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

There have been several reforms in mental health internationally, nationally and across Australian jurisdictions since the Act's development and commencement in 2014.

2.1 National Context

2.1.1 Mental Health Planning

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

The *Fifth National Mental Health and Suicide Prevention Plan* (Fifth Plan) includes actions that focus on improving the consistency of mental health legislation across jurisdictions and commits all governments to working together to achieve integrated regional planning and service delivery. Consumers, carers and safety and quality measures are also an integral part of the *Fifth Plan* and inform how services are planned, delivered and evaluated. Other areas of focus include suicide prevention, physical health of people living with a mental illness and reducing early mortality, improving Aboriginal and Torres Strait Islander mental health and suicide prevention and reducing stigma and discrimination for people with a mental health illness[2].

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

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[1] ABS (Australian Bureau of Statistics) 2008. *National Survey of Mental Health and Wellbeing: summary of results,* Australia, 2007. ABS cat. no. 4326.0. Canberra: ABS, available from www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/6AE6DA447F985FC2CA2574EA00122BD6/$File/National%20Survey%20of%20Mental%20Health%20and%20Wellbeing%20Summary%20of%20Results.pdf (last accessed 20 August 2019). See also DoHA 2013. *National Mental Health Report 2013: tracking progress of mental health reform in Australia 1993 – 2011*. Canberra: Commonwealth of Australia.

[2] The Fifth Plan and accompanying Implementation Plan can be accessed here: www.coaghealthcouncil.gov.au/Publications/Reports (last accessed 29 August 2019)

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

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

Safety and quality in mental health care has been a key priority nationally and has been influenced and supported by the development of the *National Standards for Mental Health Services 2010*[4] (National Standards), the *National Mental Health Statement of Rights and Responsibilities 2012*[5], and movement towards the elimination of seclusion and restraint in Australian mental health services through the development of *National Principles to Support the Goal of Eliminating Mechanical and Physical Restraint in Mental Health Services*[6].

The *National Framework for Recovery-Oriented Mental Health Services*[7] was developed in 2013 and is based around the needs of consumers, carers and their families utilising their lived experience of mental health to inform treatment and support. Self-determination, personal responsibility and self-management are a key focus of the framework. The framework aligns with the current national focus on rights, recovery orientated approaches and supported recovery identified in the National Standards and broader reform agendas.

2.1.2 Funding and Service Delivery

Mental health services in Tasmania are funded by both the Tasmanian and Australian Governments.

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

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[3] The Roadmap can be accessed here: www.coag.gov.au/sites/default/files/communique/The%20Roadmap%20for%20National%20Mental%20Health%20Reform%202012-2022.pdf (last accessed 29 August 2019)

[4] The National Standards can be found here: www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-servst10 (last accessed 29 August 2019)

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

[6] The National Principles can be found here: www.mentalhealthcommission.gov.au/media/192035/National%20Principles%20to%20Support%20the%20Goal%20of%20Eliminating%20Mechanical%20and%20Ph....pdf (last accessed 29 August 2019)

[7] The National Framework can be found here: www1.health.gov.au/internet/main/publishing.nsf/content/67D17065514CF8E8CA257C1D00017A90/$File/recovgde.pdf (last accessed 29 August 2019)

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

- psychosocial 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, and
- 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.

2.1.3 Legislative Developments

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

- The *Mental Health Act 2015* (ACT) came into effect on March 2016. The Act is designed to empower people to participate in decisions about their health care and sets out the legal responsibilities of doctors and other professionals. It promotes consumer involvement in decision-making and contains provisions that support consumers to make their own decisions.
- The *Mental Health Act 2016* (Qld) commenced in March 2017. The Act's objects include to improve and maintain the health and wellbeing of people who have a mental illness and who do not have the capacity to consent to be treated.
- The *Mental Health Act 2014* (Vic) seeks to place people with mental illness at the centre of decision-making about their treatment and care. It encourages psychiatrists and other mental health practitioners to develop strong relationships with people using mental health services, and to provide them with information and support to make informed choices about their care. It promotes voluntary treatment over compulsory treatment.
- The *Mental Health Act 2014* (WA) commenced in November 2015. It is primarily relevant to people experiencing mental illness who, because of the seriousness of the illness and issues in compliance with treatment, need to be made subject to involuntary status.

2.2 Tasmanian Context

2.2.1 History of the *Mental Health Act 2013* (Tas)

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

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

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

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

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

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

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

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 MHT about certain aspects of the legislation. The 2016 amendments took effect on 1 July 2017.

Other more recent amendments to the Act include:

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

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

2.2.2 Mental Health Planning

The Tasmanian Government released *Rethink Mental Health: A long-term plan for Mental Health in Tasmania 2015-2025* (Rethink) in 2015 following an extensive stakeholder consultation process. Rethink sets a vision for Tasmania to be a community where all people have the best possible mental health and wellbeing and brings together actions to strengthen mental health promotion, prevention and early intervention, to improve care and support for people with mental illness, their families and carers. It includes short, medium and long-term actions to develop an integrated mental health system that provides support in the right place, at the right time and with clear signposts about where and how to get help[8].

Approaches to achieving integration of mental health services in Southern Tasmania were considered by the Mental Health Integration Taskforce (the Taskforce). The Taskforce noted slow progress in achieving the commitment set out in Rethink to develop an integrated mental health system and considered reasons for this over a 12-month period from March 2018 to March 2019. The Taskforce made 21 recommendations for achieving lasting system change. Amongst other key reforms the Taskforce recommended establishing an 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[9]. The Tasmanian Government has accepted all Mental Health Integration Taskforce recommendations, and actions are currently underway to implement a fully integrated mental health system in Tasmania.

In 2016 the Tasmanian Government released an updated *Tasmanian Carer Policy*. The policy recognises the commitment of unpaid Tasmanian carers and supports them in their caring role, and their active participation in economic, social and community life for themselves and the people they care for[10]. The findings of Mental Health Carers Tasmania's *Caring Voices Project* also provided insight into the role of, and issues faced by, mental health carers in Tasmania[11].

2.2.3 Funding and Service Delivery

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

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

- 24-hour acute inpatient services located at three public hospitals (the Royal Hobart Hospital, the Launceston General Hospital and the North West Regional Hospital Burnie Campus)
- a 24-hour older persons acute/sub-acute inpatient unit located in the South providing services to people across the state (the Roy Fagan Centre)

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[8] Department of Health and Human Services, *Rethink Mental Health: A long-term plan for Mental Health in Tasmania* 2015-2025. April 2015 (Rethink) can be found online here: www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/202496/DHHS_Rethink_Mental_Health_WEB.pdf (last accessed 29 August 2019)

[9] Documentation relating to the Taskforce, including the Taskforce's Final Report can be found online here: www.dhhs.tas.gov.au/news/2019/mental_health_integration_taskforce_report (last accessed 29 August 2019)

[10] The Tasmanian Carer Policy can be found online here: www.dpac.tas.gov.au/divisions/csr/policy/Policy_Work/carer_policy_and_action_plan (last accessed 29 August 2019).

[11] Tasmania Medicare Local, COTA Tasmania and Mental Health Carers Tasmania, Caring Voices Project, April 2015.

- 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.

2.2.4 Legislative Developments

2.2.4.1 *Guardianship and Administration Act 1995* (Tas)

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

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

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

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

2.2.4.2 Defence of Insanity and Fitness to Plead

The TLRI also recently reviewed the Defence of Insanity in section 16 of the *Criminal Code Act 1924* and fitness to plead. An Issues Paper was released in February 2019 and this was referred to in the Consultation Document.

The TLRI's Final Report was released in December 2019. Amongst other matters the Final Report's recommendations include the need to shift from the current test for fitness to stand trial contained in the *Criminal Justice (Mental Impairment) Act 1999* to focus on the accused's decision-making capacity as a means of determining whether he or she can effectively participate in the trial, rather than on his or her cognitive capacity. The Final Report also recommended:

- making changes to the current defence of insanity contained in section 16 of the *Criminal Code Act* (Recommendation 22)
- amending the *Criminal Justice (Mental Impairment) Act* to abolish the indefinite nature of forensic orders and to introduce limiting terms (Recommendation 40)
- that the Tasmanian Government should initiate a review to identify the barriers in the forensic mental health system to patients' reintegration into the community with a view to ensuring that appropriate pathways are available for the gradual reintegration of forensic patients in the community, consistent with the principles of least restriction and community safety (Recommendation 50)
- that as part of the review of the transition pathways from a restriction order to a supervision order, consideration should be given to the amendment of the leave provisions so that any order can be made allowing forensic patients to leave the secure mental health unit for an extended period (Recommendation 51)
- that as part of the review, the use of technological solutions to overcome concerns in relation to risk and community safety should be considered (Recommendation 52), and
- that rehabilitation pathways should be developed for people with intellectual disabilities or cognitive impairments. The TLRI recommends that this matter be addressed in the review of the "step down" pathways for forensic orders (Recommendation 54).

The Government is currently considering the TLRI's Final Report.

2.3 Other Developments

2.3.1 United Nations Convention on the Rights of Persons with Disabilities

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

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

2.3.1.1 Supported Decision-Making

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

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

2.3.2 Optional Protocol to the Convention Against Torture

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

The first part of the system is periodic visits to places of detention conducted by the United Nations Subcommittee for the Prevention of Torture (the UN Subcommittee). Australia is obliged to receive visits from the UN Subcommittee now that OPCAT has been ratified.

The second part of the system is the establishment of Australia's domestic monitoring obligations under OPCAT by establishing and maintaining a cooperative network of monitoring bodies known as National Preventative Mechanisms or NPMs designated by the Australian Government and state and territory governments. The Australian Government elected to defer the establishment of NPM networks for three years.

Work is currently occurring to designate an NPM for Tasmania.

3. Overview of the Act's Provisions

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, as follows:
    - 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.

4. The Act's Objects and Mental Health Service Delivery Principles

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

4.1 The Act's Objects

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

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

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

4.1.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document provided information about the Act's objects and asked one question:

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

Nine submissions directly addressed this question.

While a small number of respondents considered the Act to be achieving its objects this view was not shared by others. For example, and according to Advocacy Tasmania:

> *"In our work, we regularly engage with people who feel that the intention of the Act is impacted by broader issues affecting the health system in Tasmania. Our clients talk of spending excessive time in Emergency Departments, under restraint and in holding patterns. Our clients also talk strongly about their experiences being taken to facilities and how difficult and traumatising they found this. Our clients regularly tell us they feel like these experiences exacerbated their mental health concerns".*

Several respondents commented on the Act's focus on people with severe mental illness who are involuntary inpatients and queried the Act's lack of coverage for voluntary patients. Such respondents suggested that the consumer rights enshrined in the Act's objects should apply to all consumers, not just those who are receiving treatment involuntarily. To this end one respondent suggested that either the scope of the Act needs to be broadened, or the objects need to be narrowed so that they align with Act itself.

One respondent commented on the term "care" and queried its omission from part (a) of the Act's objects. The respondent suggested this was a departure from the approach taken in the legislation of other jurisdictions and appeared to question what this meant in terms of the Act's focus on human rights, respect and dignity.

Several respondents provided feedback in respect of part (b) of the Act's objects, suggesting that the Act's provisions are not being interpreted in a way that promotes its objects. One reason given for this was the impact of section 218, which provides certain immunities to approved medical practitioners (AMPs), approved nurses and other statutory officials for acts or omissions done in good faith, on the capacity for oversight mechanisms to operate effectively. Issues with the operation of section 218 of the Act are explored more fully in Part 19 of this Outcomes Report.

Feedback received in respect of part (c) of the Act's objects, which is concerned with giving everyone involved with assessment and treatment clear direction as to their rights and responsibilities, suggested a general lack of awareness amongst consumers of their rights including the right to ask the Chief Psychiatrists to directly intervene, and to ask the MHT for a review. Difficulty in understanding the Act and lack of a plain English list of patient rights were cited as possible reasons for this.

In terms of part (d) of the Act's objects, which are concerned with assessment and treatment being given in the least restrictive setting consistent with clinical need, legal and judicial constraint, public safety and patient health, safety and welfare, feedback received suggested issues with the transition from more restrictive to less restrictive settings and barriers to therapeutic alternatives that prevent consumer voices from being heard.

The MHT also commented on the lack of clear linkage between the Act's objects and its operational provisions. The MHT expressed the view that this impacts on the extent to which the operational sections of the Act need to be read subject to its objects.

Review Outcome 1:

For at least some people, the Act's provisions are not being interpreted and applied in a way that promotes its objects.

Reasons given for this include a perceived lack of alignment between the Act's objects and its provisions, poor understanding of the Act's provisions, omission of voluntary patients from the Act's scope and broader issues affecting the health system in Tasmania.

4.1.2 Government Response

The Government notes feedback received on the extent to which the Act's provisions are being interpreted and applied in a way that promotes its objects, and the reasons for this.

Before turning to the ways in which the feedback can be addressed, it is necessary to talk about the Act's application to voluntary patients, and to mention reasons for the omission of the term "care" from the Act's objects.

Voluntary patients

The Act was drafted to protect the rights of people with mental illness who lack decision-making capacity, and for whom voluntary admission is not possible. Inclusion of provisions regulating voluntary admissions was thought to be contrary to the Act's focus within that context.

Voluntary admission to hospital for general health care is not legislated for and to include provisions regulating voluntary admission to hospital for a mental health condition was viewed as stigmatising.

Provisions regulating voluntary patients were not included in the Act for these reasons. The perceived need, which has been clearly conveyed in feedback to the review, to protect the rights of voluntary patients is however noted.

Care

The term "care" was removed from the Act's objects and from other relevant provisions in 2017. The term "care" was not defined in the Act but was used in several provisions, including sections 12 and 13. The amendments were progressed to:

- clarify the Mental Health Tribunal's jurisdiction by clarifying the Act's status in relation to other laws, including the *Guardianship and Administration Act*, and
- confirm that where there is a choice between using the provisions of the Act, or the provisions of another Act, to provide for a person's care the provisions of the other Act should be used to the extent that the provisions of the other Act provide the necessary authority.

Before the amendments, section 13 of the Act provided that the Act was intended to be the primary source of authority for the involuntary assessment, treatment and care of people with mental illness. Inclusion of the term "care" in section 13 led to some confusion about whether the Mental Health Tribunal had jurisdiction with respect to care-type matters for people with mental illness who lacked decision making capacity. This included decisions about a person's longer-term accommodation needs, general health care, dental care, and decisions about a person's estate.

The Act was developed to regulate decisions about psychiatric care and treatment. While the Act refers to care in some minor respects the intention was never for the Act to provide authority for decisions about care-type matters of the kind described above. The intention was rather for these matters to continue to be regulated under the *Guardianship and Administration Act* and the 2017 amendments to remove references to the term "care" were progressed in line with this intention.

Matters concerning section 218 of the Act are addressed in the Government's response to Review Outcomes 26, 27, 28 and 29.

Government Response to Review Outcome 1:

Legislative Response

The Government will consider amendments to the Act to more clearly link the Act's objects to its operational provisions and to make it easier to understand.

The Government will seek expert clinical, legal and other advice on amending the Act to either narrow its objects so that they align more closely with its provisions or to retain the Act's objects in their current form and make other amendments to extend some or all of the Act's provisions to voluntary patients.

The Government does not consider that amendments to the Act to re-insert references to "care" are required. The Government will however consider measures to support the need for holistic care and for care to be provided in a framework that is focussed on respect for human rights, respect and dignity.

Education and Training Response

The Government will develop and deliver education and training to ensure that consumers and people required to work with the Act are aware of their rights and responsibilities including the right to ask the Chief Civil Psychiatrist or Chief Forensic Psychiatrist to directly intervene, and to ask the MHT to conduct a review.

Documentation and Processes Response

The Government will review existing Statements of Rights documentation to ensure that it is clear and easy for patients and others to understand.

The Government will also work to improve processes associated with the movement of patients from more restrictive settings to settings that are less restrictive, and to remove barriers to therapeutic alternatives.

Resource-Related Response

The Government will consider any funding submissions in relation to this Review Outcome, through future Budget processes.

4.2 Mental Health Service Delivery Principles

Section 15 of the Act requires people exercising responsibilities under it to have regard to the mental health service delivery principles set out in Schedule 1 to the Act. For completeness the mental health service delivery principles are set out in full at Appendix G to this Report.

4.2.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document explained the requirements of section 15 as they concern the Mental Health Service Delivery Principles and extracted the Principles in full as an Appendix to the Document. The Consultation Document then asked one question:

- Question 2: Are people exercising responsibilities under the Act doing so in a way that has regard to the Mental Health Service Delivery Principles?

Nine of the submissions received specifically addressed this question.

Feedback received suggested that in the view of at least some Tasmanians, people exercising responsibilities under the Act are not doing so in a way that has regard to the Mental Health Service Delivery Principles.

Tasmania Police submitted that:

> *"… on many occasions, the principles … are not being exercised. Police are often requested to attend to persons who appear to be affected by mental illness, when according to the principles trained medical professionals should be attending to the needs of the person. Uniform police are often used as the primary responder to concerns for welfare of persons who appear to be mentally unwell, where no threat of violence is present. This may impinge on their right to dignity and self-respect by uniform police attending and implying a stigma of unlawfulness to the person, and such a perception to other members of the community witnessing the interaction, when the reality is that the person is suffering a health issue".*

The Southern FLAG noted that while "the Mental Health Service Delivery Principles seem to be an excellent set of guidelines … it's the consumer's experience that they are rarely if ever met".

One respondent suggested that the Act needs to focus on the government's obligation to respect, promote and fulfil human rights rather than maintain the current narrow focus on respecting, observing and promoting human rights, suggesting that the Act's current focus:

> *"… reveals apparent ambivalence about a human rights culture, and a nervousness which is unnecessary. Good order in a mental health facility can be shown on the evidence to be just as possible, if not more possible, where there is a culture of respect and dignity for people who are unwell… On evidence, Tasmania will benefit from a human rights culture that promotes health and well-being for individuals and community, and ultimate economic productivity if we choose that as the overriding goal. The key message … is that a human rights culture simplifies and resolves and gets results".*

Several respondents suggested the need to be more specific about what the right to dignity, self-respect, liberty, autonomy and other inherent rights look like, and entail, and to consider rights in terms of processes and outcomes that are capable of being measured and evaluated. Aligned with this feedback were comments suggesting a disconnect between the Act's principles, its structure and its provisions with one respondent commenting as follows:

> *"Dignity, Self-Respect, Liberty, Autonomy, Rights, these are just words laid out in a document that eradicates these words by its own complexities. How can anyone determine their rights, attain dignity, argue for their self-respect, obtain liberty and be autonomous if they can't understand the rules and regulations … or how to find them in the Act".*

One respondent suggested the need to consider whether, and if so how, the Act might reference rehabilitation and sexual safety and the need for trauma informed policy and process in mental health facilities.

As with Question 1, respondents to Question 2:

- noted the unenforceability of the principles and queried whether inclusion of an immunity provision is consistent with a rights-based framework, and
- commented on the Act's lack of coverage with respect to voluntary patients.

Several respondents commented on their experience of the attitudes and actions of some staff which were reported by those respondents to be not reflective of the Mental Health Service Delivery Principles and to reflect a lack of a human rights culture that promotes health and well-being for individuals and community and respect and dignity for people who are unwell.

Feedback with respect to Principle (h), which requires people exercising responsibilities under the Act to recognise the difficulty, importance and value of the role played by families, and support persons, of people with mental illness was mixed. While one respondent stated that the role of the family is understood and valued in the application of the Act, and that families and support people are involved in decision-making, another respondent commented on the failure for family, friends and carers to be kept informed of relevant matters even if the consumer has specifically requested it and commented that families and support people felt dismissed and not recognised as valuable or partners of mental health service providers.

The Mental Health Act Review Statutory Reference Group discussed the location of the Mental Health Service Delivery Principles and queried why the Principles are in a Schedule to the Act rather than upfront and in the body of the Act.

Review Outcome 2:

People exercising responsibilities under the Act are not always doing so in a way that has regard to the Mental Health Service Delivery Principles.

Reasons given for this are similar to the reasons relating to Outcome 1 and include a perceived lack of alignment between the Act's principles and its provisions, difficulties in understanding the Act's requirements due to its complexity and structure, lack of a human rights culture that promotes health and well-being for individuals and community and respect and dignity for people who are unwell.

4.2.2 Government Response

Feedback received on the extent to which people exercising responsibilities under the Act in a way that has regard to the Mental Health Service Delivery Principles, and the reasons for this, are noted.

The issue of where the Mental Health Service Delivery Principles should appear in the Act, and whether this should be in the body of the Act or in a Schedule, was carefully considered during the Act's development. The inclusion of the Principles in the body of the Bill was considered but ultimately not adopted for two main reasons:

- Firstly, the Principles are binding on everyone exercising responsibilities under the Act regardless of whether they are in the body of the Act or in a Schedule. That is, the location of the Principles in the Schedule does not dilute or in any way change their legal effect.
- Secondly, and pursuant to section 226 of the Act the Governor may, by order, amend Schedule 1 at any time. Locating the Principles in the Schedule means therefore that they can be added to or otherwise updated as and when necessary to reflect shifts in mental health practice and policy. The *Mental Health Act 1996* had been criticised for being out of date and the inclusion of provisions enabling the Principles to be updated by the Governor without the need for an amending Act was viewed as an important way of ensuring that the Act remained contemporary.

It is timely to reconsider this decision considering feedback received through the review process.

Government Response to Review Outcome 2:

Legislative Response

The Government will consider amendments to the Act to make it easier to understand and to more clearly link the Mental Health Service Delivery Principles to the Act's operational provisions.

The Government will also consider amendments to ensure that the Mental Health Service Delivery Principles remain contemporary and to include the Mental Health Service Delivery Principles in the body of the Act rather than in a Schedule. Amendments that may be considered as part of this process include amendments to more clearly demonstrate what the right to dignity, self-respect, liberty, autonomy and other inherent rights look like, amendments to reference sexual safety and rehabilitation and trauma-informed policy and process, and amendments to emphasise the Government's obligation to actively respect, promote and fulfil human rights.

Education and Training Response

The Government will develop and deliver education and training to clinicians and others on the Mental Health Service Delivery Principles to support clinicians who are required to exercise responsibilities under the Act to do so in a way that has regard to the Principles, promoting health and wellbeing for individuals and the community, and respect and dignity for people who are unwell.

5. Key Concepts

5.1 Decision-Making Capacity

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

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

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

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

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

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

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

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

The Chief Civil Psychiatrist and Chief Forensic Psychiatrist Clinical Guideline 2 – Decision-Making Capacity provides guidance on matters including the assessment of decision-making capacity for children and adolescents, people who are intoxicated, and other circumstances requiring special consideration. Clinical Guideline 2 can be found online here:
www.dhhs.tas.gov.au/__data/assets/pdf_file/0009/252747/CCP_Clinical_Guideline_2_-_Capacity.pdf

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

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

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

5.1.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document provided information about decision-making capacity and asked one question with respect to it, as follows:

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

Nine submissions specifically addressed the issue of decision-making capacity.

Respondents were generally supportive of the test for decision-making capacity as it is set out in section 7 of the Act. Respondents were particularly supportive of the inclusion of a test for decision-making capacity in the Act, and of the decision to make decision-making capacity a threshold criterion. For example, the LACT expressed the view that:

> *"… the Act has improved our clients' treatment experiences and outcomes. The assumption that a person has decision-making capacity and can provide informed consent or refusal to their mental health assessment and treatment is a significant strength of the Act. This protection is supported by the codified framework and processes that must be followed to effect involuntary assessment or treatment. The Act's focus on decision making capacity and autonomy is a welcome protection of Tasmanian's human rights and is in keeping with the UN Convention on the Rights of Persons with a Disability which Australia has ratified".*

Another respondent expressed specific support for the requirement to take a least restrictive approach in the context of not automatically assuming that a person is unable to make their own decisions, and to exhaust all other options to support them to do so before making a determination that they lack decision-making capacity. These requirements are consistent with placing the consumer at the centre of decision-making processes and supporting them to direct their own recovery and wellness.

Some respondents however expressed concern about how the test is operating. For example:

- The LACT expressed their observation that the processes of assessing capacity by clinicians do not consistently promote voluntary over involuntary treatment or the exercise of free choice and expressed the view that that decision-making capacity assessment processes often fail to support informed consent as they don't:
    - provide clients with enough explanation and information about diagnosis and treatment options
    - provide time to ask questions and consider the information and options, or
    - provide the opportunity to get a second opinion.

The LACT linked this to a low level of understanding in practice about what informed consent and lack of decision-making capacity mean despite the definitions in the Act. As a result, and in the LACT's view the test is "set too high" and sees people who have capacity to consent and to refuse consent being treated involuntarily.

- Advocacy Tasmania said that many clients tell them they believe that the test used to determine decision-making capacity is not operating well or appropriately for their circumstances.
- One respondent suggested that while the Act demonstrates reasonably clearly how the assessment procedure for capacity should proceed, there are some clinicians who continue to believe that a person with mental illness automatically lacks decision-making capacity.
- Carers Tasmania reported some carers as being of the view that some clinicians presumed in favour of decision-making capacity when it was the carer's view that this was severely compromised.

Several respondents questioned how well the test for decision-making capacity is understood in practice. For example:

- One respondent observed confusion about the assessment of decision-making capacity and the bar for establishing risk of serious harm to others while another suggested that there appears to be a low level of understanding in practice about what informed consent and lack of decision-making capacity mean, despite the definitions in the Act.
- The LACT suggested there is an apparent lack of agreement and consistency by clinicians about what constitutes decision-making capacity, and varying methods of assessing decision-making capacity despite the Chief Civil Psychiatrist's Clinical Guideline which provides guidance on this. The LACT also suggested that:
    - in the LACT's view, the phrase "lack of insight" is used when considering whether a person lacks decision-making capacity instead of applying the tests for informed consent that are provided for in the Act, and
    - patient disagreement about diagnosis is interpreted as being an "absolute indicator" of lack of decision-making capacity.

The LACT also observed a general lack of understanding that decision-making capacity in adults is to be presumed under the Act. In the LACT's observation, for clients who have been under the Act for a long time this lack of understanding means that decision-making capacity is assessed afresh at each point of contact. In other cases, the LACT noted that clinicians have been observed to take previous relapses due to stopping medication as evidence that a person lacks decision-making capacity. This denies the person the opportunity to learn from relapse experiences.

Several submissions commented on how decision-making capacity should be assessed and queried whether this should be assessed at a particular point in time (on a cross-sectional basis) or against a person's background, taking into account their life experience, beliefs and aspirations over a period of time (on a longitudinal basis). Views about the approach that should be taken varied:

- The LACT noted a practice of referring to longitudinal assessment of decision-making capacity and suggested that in their view, this does not appear to be supported by the Act, which requires all adults to be deemed to possess decision-making capacity for assessment and treatment unless the relevant decision-maker is satisfied otherwise.

- The MHT's submission confirmed that there are conflicting views about how capacity should be assessed within the framework established by the Act and noted that the Tribunal uses both the cross-sectional and longitudinal approach to give an indication of capacity with assessment being made on a case by case basis depending on the duration and acuity of the person's illness.
- The RANZCP Tasmanian Branch also commented on how decision-making capacity should be evaluated suggesting that a cross-sectional assessment is "a necessary part in all situations requiring determination of decision-making capacity but needs to be qualified by historical evaluation of such capacity as [psychiatrists] are usually dealing with people with protracted mental illness". The Branch noted that, in their view, one of the aims of the Act is to provide appropriate and effective treatment and suggested that adopting a cross-sectional approach alone could lead to frequent and contrary evaluation results for decision-making capacity on any particular patient, leading to repeated inpatient admissions and discharges, frequent changes of treatment and treatment approach, treatment being ceased without advice and ultimately, relapse of illness.

The LACT also queried whether capacity should be considered an "all or nothing" proposition in relation to mental health treatment and expressed the view that the MHT consistently finds that it is. The LACT provided the example of a person who may be able to provide informed consent to antidepressants but not antipsychotics to illustrate the problematic nature of such an approach.

Several respondents provided commentary on the test for decision-making capacity in terms of the "threshold" that it sets before a person may be assessed or treated involuntarily. One respondent suggested that the test for decision-making capacity is set too high and that as a result, people are treated involuntarily when they have sufficient capacity to consent to and, particularly, to refuse, treatment. Conversely, other respondents appeared to suggest that the bar is set too low.

The RANZCP Tasmanian Branch referred to Mr Justice Bell's decision in the Victorian case of *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 (1 November 2018, revised 22 January 2019) when considering the issue of decision-making capacity and queried whether an insertion to the Act should be considered to "help clarify the issues".

In terms of the test itself, the RANZCP Tasmanian Branch queried the reference in subsection 7(3)(b) of the Act to a person being able to retain information relevant to a decision "briefly". The Branch noted that the Act does not define what is meant by "briefly" and suggested the reference be removed "as it is unnecessary and does not reflect clinical practice with long term illnesses".

In respect of the test's application to children, the Commissioner for Children and Young People Tasmania (the Commissioner for Children) noted that she had been advised that:

> *"in some situations, it is not entirely clear who may provide consent for assessment or treatment for a child who lacks decision-making capacity. Uncertainty may arise where a parent or guardian is unavailable or unwilling to provide consent, where a parent is themselves incapable of providing informed consent, where there is a dispute between parents or between parents and the child about the appropriateness or otherwise of the assessment or treatment proposed, or where the child lives independently and/or is estranged from family".*

Several respondents commented on supported decision-making approaches. In this context Advocacy Tasmania specifically suggested the need to consider the Act in tandem with other reforms arising from the TLRI's review of the *Guardianship and Administration Act*.

The MHT also noted the TLRI's review of the *Guardianship and Administration Act* including the TLRI's proposal to replace decision-making capacity with "decision-making ability". The MHT expressed its opposition to a proposal of this kind for the Act, stating that:

- Capacity requires the application of a certain skill set to a requisite standard to deal with a certain problem. In order to show capacity a patient must demonstrate how to apply knowledge to a particular problem in order to make a decision. Capacity is task focused.
- On the other hand, the word "ability" implies the need to be able to make a decision but says nothing about the nature and effect of the decision making. Further, "ability" is focussed on future, and does not address a person's current abilities.
- Adopting the term "decision-making ability" may be appropriate for supported decision-making but not for substituted decision-making as is the case under the Act.

Review Outcome 3:

While the test for decision-making capacity contained in the Act is generally considered to be appropriate there is some concern about how the test is operating.

The main reason for this appears to be the lack of a good or shared understanding about the requirement for decision-making capacity to be presumed and about how the test should be interpreted and applied in practice.

5.1.2 Government Response

Feedback received on the Act's operation with respect to decision-making capacity, the detailed nature of the submissions received on this matter and the apparent differences of opinion that exist about whether capacity should be assessed longitudinally or on a cross-sectional basis, are noted.

The Government's Response to issues associated with the test's application to children are addressed below in the Government's Response to Review Outcome 10.

Government Response to Review Outcome 3:

Legislative Response

The Government will review the Victorian Supreme Court's decision in *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 (1 November 2018, revised 22 January 2019), the findings and recommendations of Coroner McTaggart following the holding of an inquest under the Tasmanian *Coroner's Act 1995* into the death of Edward Paisley Peck (26 September 2019) and any other relevant judgments and seek expert legal, clinical and other advice to determine how a person's decision-making capacity should be assessed. The Government will consider amendments to the test for decision-making capacity contained in the Act should this be considered necessary as a result of these processes.

The Government will consider the need to amend the Act to refer to "decision-making ability" and to reflect concepts of supported decision making as part of the Government's consideration of and response to the TLRI's recommendations following its review of the *Guardianship and Administration Act 1995*.

Education and Training Response

The Government will develop and deliver education and training to ensure that clinicians who assess decision-making capacity promote voluntary over involuntary treatment and the exercise of free choice by ensuring that consumers are provided with enough explanation and information about diagnosis and treatment options and time in which to ask questions and consider the information and options, and the opportunity to get a second opinion.

The Government will develop and deliver education and training to ensure that clinicians have a better understanding in practice of what informed consent and decision-making capacity mean when referred to in the Act so that people who have capacity and refuse consent are not treated involuntarily.

The Government will develop and deliver education and training to ensure that clinicians understand the requirement to start from a presumption that a person with mental illness has decision-making capacity rather than the opposite.

The Government will develop and deliver education and training with input from all stakeholders to ensure more consistent application of the test for decision-making capacity at every stage of a person's assessment and treatment pathway.

The Government will also develop and deliver education and training on the importance of speaking with family members and others when assessing a person's decision-making capacity.

Documentation and Processes Response

The Chief Psychiatrists will consider amending Chief Civil Psychiatrist and Chief Forensic Psychiatrist Clinical Guideline 2 – Decision-Making Capacity to increase clarity of understanding about how the test for decision-making capacity should be applied in practice.

5.2 Meaning of Mental Illness

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

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

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

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

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

The Chief Civil Psychiatrist Clinical Guideline 1 – Meaning of Mental Illness clarifies how the meaning of mental illness is to be applied in practice. The Clinical Guideline was first released in 2014 and remains largely unamended. It is available online here: www.dhhs.tas.gov.au/__data/assets/pdf_file/0008/252746/CCP_Clinical_Guideline_1_-_Meaning_of_Mental_Illness.pdf

5.2.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document provided information about the meaning of mental illness set out in the Act and asked one question, as follows:

- Question 4: Is the meaning of mental illness set out in section 4 operating as intended? Is it easy to understand and apply?

Six submissions specifically addressed this question.

In general, feedback received suggested that the meaning of mental illness set out in section 4 of the Act is operating effectively.

Several respondents commented on the ability for the meaning of mental illness to be met without a formal clinical diagnosis, with one respondent commenting as follows:

> *"By allowing detention based on behaviour, there has been an influx of people intoxicated from drug or alcohol use who should not be detained under the Act but are because their behaviour often mimics psychosis. If the assessment protocols were not so flawed these people would be released as soon as the reason for their behaviour was detected".*

In terms of how easy it is to understand and apply the meaning of mental illness, several respondents suggested ways in which the meaning could be redrafted to improve clarity and understanding. One respondent suggesting that the meaning would "read easier" if whole sentences were used while another (the Public Guardian, via the Mental Health Act Review Statutory Reference Group) queried whether the list of exclusions in subsection 4(2) of the Act could be summarised or simplified. A third respondent suggested differentiating between mental illness and mental disorder, as occurs in New South Wales, although the rationale for the suggestion was not readily identifiable.

The MHT suggested the need to emphasise that it is not necessary for a person to have a diagnosis to come within the ambit of the Act. In the MHT's view, all that is required is for a person to have:

- a serious impairment of thought (which may include delusions), or
- a serious impairment of mood, volition, perception of cognition.

This would also recognise that a person's diagnosis may change over time. The Mental Health Act Review Statutory Reference Group discussed the meaning of mental illness and its application to dementia. Members of the Group noted that as dementia does not respond to treatment in the same way as psychotic illness, it would not be appropriate for the meaning to apply to this condition.

Members of the Mental Health Act Review Statutory Reference Group also discussed the Act's application to delirium and agreed that there was a need for better education and training in this regard.

Review Outcome 4:

The meaning of mental illness set out in section 4 is operating as intended. It is easy to understand and apply but could be made easier to understand with better education and training and if minor changes were made to the drafting.

5.2.2 Government Response

Feedback received on the Act's operation with respect to the meaning of mental illness set out in section 4 of the Act is noted.

Government Response to Review Outcome 4:

Legislative Response

The Government will consider amending the meaning of mental illness so that it is easier to understand.

The Government will review relevant legislation in place in New South Wales to identify how the term "mental disorder" is used and to assess whether there is merit in adopting the term in the Act.

Education and Training Response

The Government will develop and deliver education and training to assist in the Act's application to people with dementia and delirium.

Documentation and Processes Response

The Chief Psychiatrists will consider amending Chief Civil Psychiatrist Clinical Guideline 1 – Meaning of Mental Illness to confirm that it is not necessary for a person to have a diagnosed mental illness to come within the meaning of the Act and to clarify how the meaning applies to people who are intoxicated and whose behaviour "mimics" psychosis.

6. Assessment Framework and Assessment Orders

6.1 Assessment Framework

Meaning of Assessment

For the purposes of the Act, assessment is defined in section 5 as the clinical process involved in diagnosing the condition of a person's mental health and, where necessary, identifying the most appropriate treatment.

The Act refers to assessment with informed consent and identifies the circumstances in which a person's consent to assessment may be taken to be informed. It also refers to assessment under authority of an Assessment Order.

Assessment with Informed Consent

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

Assessment under an Assessment Order

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

Assessment Without Informed Consent or an Assessment Order

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

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

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

6.1.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document clarified aspects of the assessment framework and asked two questions in respect to these matters:

- Question 5: Is the assessment framework established by the Act operating effectively and efficiently? Is it easy to understand and apply?
- Question 6: Should the Act specifically regulate, or prevent, assessment without informed consent or an Assessment Order?

Nine of the submissions received addressed one, or both, of these questions.

In terms of the assessment framework generally, one respondent commented that while the Act makes it relatively easy to understand the processes relating to assessment, the provisions are poorly understood and misused or abused.

Carers Tasmania stated the following:

> *"… carers experience frustration that their intimate knowledge is not factored into assessment processes…. In general, feedback regarding assessments is that they are also too brief, failing to see changes to behaviour and function and don't occur in the normal living context of the person but in emergency departments and in times of crisis. Carers are frustrated clinicians do not always understand how stressful the assessment processes are for them, and don't speak of being offered any support".*

Some consumers also expressed desire to be able to see their assessments and have input to them.

The LACT provided feedback on the terms "examine" and "examination", noting that while the terms are used at various points in the Act, they are undefined, and in the LACT's view, this causes confusion. The LACT provided several examples to illustrate this point, including the reportedly routine practice of carrying out assessments against the treatment criteria at the first examination and making of an Assessment Order.

The MHT also observed difficulties with the terminology used to describe processes associated with assessments. The MHT referred specifically to the use of words such as monitor and evaluate, as well as examine, and (as with the LACT) expressed the view that this is confusing in some sections as (in the MHT's view) there would appear to be no obvious difference between the meanings of the various terms.

In terms of how the assessment framework is applied, the LACT noted a range of issues that relate primarily to Assessment Orders. This feedback is explored further below.

Several respondents commented on whether the Act should specifically regulate, or prevent, assessment without informed consent or an Assessment Order.

Several submissions received expressed support for the view that the Act should specifically regulate, or prevent, assessment without informed consent or an Assessment Order. The LACT was clear in its support for the need for clarity in this respect, citing concerns about people who report being assessed without informed consent in circumstances where the information from the assessment is then relied upon to apply for a Treatment Order. The ACMHN Tasmanian Branch was also firm in its view that the Act should specifically regulate or prevent assessment without informed consent if it is to remain consumer focussed.

Several respondents commented on the need for rigour in the assessment process, commenting that scenarios where consumers are assessed under false pretences should not be allowed to occur, that the person being assessed should be informed that they are being assessed for the purposes of the Act and that the Act should regulate assessment in a manner that allows for transparency and accountability.

The RANZCP Tasmanian Branch and the MHT expressed alternate views.

The RANZCP Branch noted that assessment of psychiatric patients can take many forms and is not necessarily confined to a formal interview with clear ground rules and procedures, and that this was particularly the case in emergency situations or when dealing with guarded or paranoid patients. The Branch commented specifically on and expressed support for the Supreme Court's unreported judgment (referred to above) which, in the Branch's view, reflected understanding of issues that can arise in assessment on a case by case basis in clinical practice.

The MHT in turn queried the need for informed consent in the context of assessment processes and queried the meaning of the phrase "assess without informed consent". According to the MHT:

> *"The term informed consent is usually used in relation to physical treatment, so that administering treatment without informed consent will amount to an assault. Assessment is defined in [section 5] of the Act as the clinical process involved in diagnosing the condition of a person's mental health and, where necessary, identifying the most appropriate treatment. As such, assessment is typically done through observation without the need for physical contact, so there will be no consequent assault".*

Review Outcome 5:

While the assessment framework established by the Act is, in general, operating effectively and efficiently, there are aspects of the framework that could be better understood and applied in ways that are more inclusive of consumers and carers. There are additionally some issues with the terminology used to describe processes associated with assessments.

While some people think that the Act should specifically regulate, or prevent, assessment without informed consent or an Assessment Order this view is not shared by others.

6.2 Assessment Orders

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

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

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

Application

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

When May an Assessment Order be Made?

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

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

Assessment Criteria

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

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

Independent Assessment

Once an Assessment Order is made the following applies:

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

Duration

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

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

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

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

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

Discharge

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

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

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

6.2.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question with respect to Assessment Orders, as follows:

- Question 11: Are provisions of the Act relating to Assessment Orders operating effectively? Are they clear and easy to understand?

11 respondents provided feedback with respect to the operation of the Act's provisions for Assessment Orders.

Of the submissions received, only one respondent expressed the view that the Assessment Order provisions are operating effectively.

Staff of the Tasmanian Health Service commented on the inability to provide an involuntary patient subject to an Assessment Order with treatment unless urgent circumstances treatment is authorised. Staff suggested that "the initial Assessment Order for 24 hours should have urgent circumstances treatment as well". According to some staff, this would simplify the process and reflect what effectively happens in Emergency Departments currently. As one staff member put it:

> *"Consider the scenario … an [Emergency Department] Medical Practitioner assesses a patient and they meet the criteria for an Assessment Order…This causes difficulties in managing the patient while awaiting an assessment by an AMP. In regional areas this can take a few hours and occasionally the patient is escalated ending in restraint. If the medical practitioner in the [Emergency Department] is given the authority to treat this would reduce the agitation to the patient and avoid restraint".*

Respondents also commented on time periods for Assessment Orders, as follows:

- The Southern FLAG observed that some staff seem to experience difficulty in meeting the timelines outlined in the Act for Assessment Orders.
- Staff of the Tasmanian Health Service noted that the maximum of 72 hours after an Assessment Order affirmation and before an interim Treatment Order is required causes significant logistical issues as the MHT is not available 24 hours a day, 365 days of the year. Staff expressed the view that the rights of the individual may be "inadvertently adversely impacted upon" by this aspect of the Act. Staff noted that it may mean that on a Friday an interim Treatment Order is applied for and granted after a relatively brief period of assessment (in some cases, the person may have been on the Assessment Order for only a few hours) when it may be more appropriate that the person is assessed later and the interim Treatment Order application is made then. Staff suggested that as a solution, an Assessment Order's maximum period after affirmation of 72 hours should not include weekends or public holidays, as is reportedly the case in other jurisdictions. Staff alternatively suggested that the Assessment Order's maximum period after extension could be extended to 96 or 120 hours.
- The RANZCP Tasmanian Branch also noted problems in practice in certain situations with the time requirements set out for the affirmation or discharge of Assessment Orders and noted that as a result of these problems Assessment Orders often expire before an interim Treatment Order can be made. The Branch outlined the scenario of patients who are detained in Emergency Departments under an Assessment Order and who arrive on the inpatient unit on a Friday with most of the "extended assessment time" under subsection 32(4) of the Act (72 hours from the time of affirmation) already elapsed. Over a normal weekend, according to the Branch, interim Treatment Orders cannot always be submitted after 3.00 pm on Friday or before 9.00 am on a Monday; this has,

at times, led to the making of a further Assessment Order which is contrary to the spirit of the Act but "not specifically prohibited by it".

The MHT also commented on the making of repeat Assessment Orders. The MHT confirmed that the Act is silent as to whether a second Assessment Order can be made (and affirmed) after the original Assessment Order has expired and commented that:

> *"It could be argued that the making of an additional [Assessment Order] is highly undesirable, as it potentially allows patients to be detained for significant periods with little independent oversight. It should also be noted that the validity of an [Assessment Order] can have significant impact on subsequent actions under the Act. An invalid [Assessment Order] will mean that a patient is not involuntary, which is a pre-requisite for any urgent circumstances treatment authorised under section 55, or seclusion authorised under section 56, or restraint authorised under section 57. Further, the validity of an [Assessment Order] will determine under which section any application for a [Treatment Order] is made. If the application is made under section 37(3) of the Act, and the assessment is invalid, then the application will also be invalid".*

In terms of documentation:

- The LACT noted that clients report not being given copies of Assessment Orders in a timely manner, or at all, as required by section 29(a) of the Act.
- The Southern FLAG noted that patients are sometimes not given a copy of the Assessment Order to which they are subject. The Southern FLAG also noted that consumers find it hard to know and access their rights when subject to an Assessment Order, and information for consumers and carers about the process is difficult to find.

Some respondents commented on specific aspects of the provisions, as follows:

- The LACT commented on the different language used in subsection 30(1) of the Act, which requires a person to be independently assessed within 24 hours from when an Assessment Order is made, and in subsection 37(4), which refers to separate assessments.
- In respect of the requirement for patients to be given copies of Assessment Orders that are made, the LACT also noted that under section 11, any required actions under the Act must occur "as soon as reasonably practicable" but that no further guidance is given as to what this phrase means.
- The Southern FLAG noted that while the Act requires the patient to be advised if an Assessment Order is affirmed it does not mention if the affirmation is to be in writing to the patient.

Review Outcome 6:

Provisions for Assessment Orders are not operating effectively nor are they easy to understand and apply.

Reasons for this include lack of clarity about the circumstances in which a person who is subject to an Assessment Order may be provided with treatment unless urgent circumstances treatment is authorised, difficulty meeting the timeframes set out in the Act for the making and affirmation of Assessment Orders and Treatment Orders, and lack of clarity in the Act's provisions.

6.2.2 Government Response

Feedback received on the assessment framework established by the Act and on the operation of provisions for Assessment Orders is noted.

Matters concerning the regulation of emergency treatment and provision of treatment to people on Assessment Orders generally are covered below and in the Government's Response to Review Outcomes 7, 8 and 9.

Government Response to Review Outcomes 5 and 6:

Legislative Response

The Government will consider amending the Act to clarify and distinguish between the terms "examine", "examination", "monitor", "evaluate" and "assessment" and to ensure that language used to describe assessments is clear and consistent.

The Government will consider amending the Act to more clearly identify the circumstances in which a person who is subject to an Assessment Order may be provided with treatment.

The Government will consider amending the Act to more clearly identify whether, and if so the circumstances in which, a second Assessment Order may be made.

The Government will consider amending the Act to clarify timeframes associated with Assessment Orders and requirements around provision of documentation to patients and others including at the point that an Assessment Order is affirmed.

The Government will seek expert clinical, legal and other advice to determine whether the Act should be amended to specifically regulate, or prevent, assessment without informed consent or an Assessment Order.

Education and Training Response

The Government will develop and deliver education and training to assist clinicians to better understand and apply the Act's provisions as they concern assessment and Assessment Orders and to explain the Act's provisions to consumers and carers.

The Government will develop and deliver education and training to support the inclusion of carers and consumers in assessment processes.

Documentation and Processes Response

The Government will identify ways to improve processes for ensuring that patients are provided with copies of Assessment Orders, Statements of Rights and other key information.

Resource-Related Response

The Government will consider any funding submissions in relation to this Review Outcome, through future Budget processes.

7. Treatment Framework and Treatment Orders

7.1 Treatment Framework

Meaning of Treatment

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

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

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

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

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

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

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

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

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

When May Treatment Be Given?

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

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

Treatment with Informed Consent

The circumstances in which a medical practitioner may take a person's consent to treatment as being informed for the purposes of the Act are set out in section 8 of the Act. Specifically, section 8 requires a medical practitioner to be satisfied that the person has decision-making capacity at the time he or she gives the consent, has given consent freely and has had a reasonable opportunity to decide. Section 8 also sets out the criteria that must be met before a person may be taken to have had a reasonable opportunity.

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

Treatment That is Authorised by the Mental Health Tribunal

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

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

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

Urgent Circumstances Treatment

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

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

The Act also provides for Treatment Orders. Treatment Orders provide authority for a person to be given, without informed consent, the treatment, or type of treatment specified in the Order.

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

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

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

The circumstances in which urgent circumstances treatment may be authorised for an involuntary patient are set out in section 55 of the Act. The circumstances in which urgent circumstances treatment may be authorised for a forensic patient are, in turn, set out in section 87 of the Act.

In each case, urgent circumstances treatment may only be authorised if the AMP authorising it is of the opinion that achieving the necessary treatment outcome would be compromised by waiting for the treatment to be authorised by the MHT, or by a member of the MHT on an interim basis.

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

Urgent circumstances treatment may be given only until:

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

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

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

The Standing Orders and Clinical Guidelines are available online here:
www.dhhs.tas.gov.au/mentalhealth/mental_health_act/mental_health_act_2013_new_mental_health_act/clinical_guidelines_and_standing_orders

Emergency Treatment

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

The Act does not regulate emergency treatment.

Emergency treatment may be given to a person who has a mental illness and is under the Act in the same way that it may be given to a person with mental illness who is not under the Act. The treatment in this circumstance is however regulated by the Common Law, not the Act.

Where additional or ongoing treatment is needed, and the emergency criteria no longer apply, then either informed consent or authorisation from the MHT or from an AMP via the urgent circumstances treatment provisions will continue to be required.

7.1.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question with respect to the treatment framework established by the Act:

- Question 7: Is the treatment framework established by the Act operating effectively? Is it easy to understand and apply?

12 of the submissions received commented on this question.

The LACT noted that the implementation of a single streamlined legislative framework for treatment of mental illness under the Act is clearer for all users and that the treatment framework established by the Act is operating well and is better than the framework established by the *Mental Health Act 1996*. In the LACT's view, this is because people are not held in hospital without treatment for more than a few days and there is more thorough oversight of ongoing treatment and processes by the MHT.

In terms of involuntary treatment, the LACT noted that most clients report that shorter term orders and more regular review hearings, and regular and ongoing assessment of medication regimes and changes to a person's mental state, promote voluntary over involuntary treatment and are better for them.

The RANZCP Tasmanian Branch also reported that overall, Fellows of the Branch who work daily with the Act would appear to be are happy with the treatment framework established by it.

Other respondents were less positive about the treatment framework established by the Act. Two respondents reported less holistic care and human-centred treatments, and too much reliance on medications. One of those respondents also commented on the variation in quality and availability of treatment in institutions across Tasmania, and in variations in the interpretation of the Act.

Several respondents provided feedback in respect of the ability to treat a person who is subject to protective custody or an Assessment Order suggesting that there is confusion about whether, and on what authority, treatment may be given to people in this situation. Staff of the Tasmanian Health Service suggested that clear legislated permission to treat early would save a lot of aggression and distress to both patients and staff in Emergency Departments. The RANZCP Tasmanian Branch commented on the ability to provide emergency treatment to a person who is subject to an Assessment Order and suggested that while advice on the circumstances in which this may occur are clear there is a need for clarity about this in the legislation.

Several respondents commented specifically on urgent circumstances treatment, as follows:

- The MHT suggested that there is confusion about when urgent circumstances treatment can commence and whether this can occur once an Assessment Order has been made or only after the Assessment Order has been affirmed.
- The LACT observed that urgent circumstances treatment is routinely authorised at the same time as the making of an Assessment Order rather than in exceptional circumstances. In the LACT's view this is of concern as the threshold for making an Assessment Order is low and authorising urgent circumstances treatment at the same time as the making of an Assessment Order effectively enables treatment to be commenced without oversight from the MHT. Treatment at this point also makes it impossible to establish whether improvement in mental state by the time of the MHT hearing is due to the medication or other matters.

- The Southern FLAG also observed that urgent circumstances treatment seems to be sought in most cases of involuntary admission and queried whether all cases can be so urgent as to "skip over" important parts of the "protocol" surrounding urgent circumstances treatment.
- The Society of Hospital Pharmacists of Australia (SHPA) expressed concern about the administration of unregistered medicines to patients that are treated under "emergency treatment orders", such as injectable lorazepam that is administered to patients under acute behavioural disturbances. According to the SHPA, the Therapeutic Goods Administration (TGA) requires medical practitioners to obtain informed consent prior to the use of therapeutic goods procured under the TGA's Special Access Scheme and that are not on the Australian Register of Therapeutic Goods and to inform patients:
    - that the therapeutic good is not approved in Australia
    - of the possible benefits of treatment and any known risks and side effects
    - that unknown risks and late side effects are possible, and
    - of any alternative treatments using approved products.

  The SHPA expressed the belief that there is a need for clarification in the Act on the appropriateness of and mechanisms for using unregistered medicines for "emergency treatment orders" where informed consent is unable to be obtained, and the roles and responsibilities for medical and health practitioners in these circumstances.
- Staff of the Tasmanian Health Service queried the need for recommendations regarding the medication that can be given to a person as urgent circumstances treatment suggesting these are unnecessary and will always be incomplete and contextual to the "rapidly changing situation at hand".

Several respondents commented specifically on treatment plans, as follows:

- The LACT suggested that treatment plans are an advantage of the Act insofar as they provide an opportunity for greater collaboration and communication between the treating team and patients. The LACT noted that "clients report that input into their treatment planning results in better therapeutic relations and more engagement in treatment outcomes".
- The RANZCP Tasmanian Branch stated that some psychiatrists have expressed frustration at the requirement to lodge treatment plans which may be incomplete and not comprehensive due to difficulty in establishing the diagnosis and which may frequently change as the illness progresses and other problems become evidence. The Branch expressed the view that this could be addressed through increased education and training of clinical staff.
- Several respondents suggested that treatment plans and the application for Treatment Order are very similar and repetitive with some respondents questioning the need for treatment plans within this context.
- Several respondents provided comments which appeared to query the extent to which clinicians understand that treatment plans are intended to be written for the patient with one respondent suggested there is a lack of guidance in how to write a treatment plan.
- The Southern FLAG commented that many patients do not have treatment plans.

Issues were also raised with specific components of the treatment framework, as follows:

- The MHT noted section 16 of the Act and queried whether the phrase "with informed consent" where it appears in part (i) of subsection 16(2)(a) includes informed consent provided by a parent under section 9 of the Act. The Tribunal also suggested a certain lack of clarity about how parts (i), (ii) and (iii) of subsection 16(2) operate to authorise treatment for involuntary patients.
- The President of the MHT and the LACT (both through the Mental Health Act Review Statutory Reference Group) noted issues with the wording of section 55 of the Act insofar as it refers to a person having a mental illness rather than reasonably appearing to have a mental illness, and to examination rather than assessment. In the President and LACT's view, these issues leave the section open to misunderstandings.

Review Outcome 7:

While the treatment framework established by the Act is operating more effectively than the framework established by the *Mental Health Act 1996*, there is a need for greater clarity in some aspects of the framework, including the circumstances in which a person who is subject to the Act's protective custody provisions or is under an Assessment Order may be given emergency treatment, and the role and purpose of treatment plans.

7.2 Treatment Orders

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

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

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

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

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

Applications

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

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

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

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

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

Determination of Applications

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

The Tribunal must be satisfied of the following matters:

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

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

Treatment Criteria

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

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

Treatment Plans

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

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

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

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

Interim Treatment Orders

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

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

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

Form and Content of Treatment Orders

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

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

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

Treatment Orders and interim Treatment Orders may additionally provide for a combination of treatment settings, and for the admission and re-admission of the person to those settings.

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

Failure to Comply with Treatment Orders

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

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

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

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

Admission to Prevent Possible Harm

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

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

This action may be taken only if:

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

Procedural Requirements

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

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

Renewal of Treatment Orders

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

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

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

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

Duration of Treatment Orders

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

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

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

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

Discharge of Treatment Orders

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

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

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

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

7.2.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question with respect to Treatment Orders, as follows:

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

12 respondents commented on this question.

One respondent expressed the view that the framework for Treatment Orders established by the Act is:

> *"… theoretically sound and easy to understand. The issues that arise tend to be due to a lack of understanding on the part of clinicians when presenting evidence to support a [Treatment Order]".*

Several respondents commented on the criteria for being placed on a Treatment Order:

- Advocacy Tasmania reported mixed feedback from involuntary patients. According to Advocacy Tasmania, one involuntary patient thought that he should not be placed on a Treatment Order as he was willing to take medication even without a Treatment Order, while acknowledging that the Treatment Order will give him longer term benefits. Another involuntary patient reportedly expressed the view that a Treatment Order accomplishes nothing except keeping the patient in hospital, and that nobody should be under a Treatment Order.
- Another respondent commented that "there are too many times that we have to wait until the person has lost the plot completely before they can be placed under an Order". The respondent suggested a means of being able to get a person's drug regime changed before the patient has a "full episode" and they end up back in hospital.
- The LACT suggested that, at times, people are being treated involuntarily when they arguably shouldn't be or are treated for "best interests" reasons which is not the purpose or intention of the Act.
- The MHT referred to Blow CJ's comments in *S v Mental Health Tribunal* [2016] TASSC 33 (13 July 2016) and noted that according to Blow CJ, the thresholds for satisfaction of the criteria in sections 40(b) and (c) are "fairly low":

  > 22. … To be satisfied as to [section 40(b)], a medical practitioner need not be satisfied of any risk to other people, nor of any risk to the safety of the patient. It is sufficient if the practitioner is satisfied that, without treatment, the mental illness is likely to seriously harm the person's health, which of course includes the person's mental health.
  >
  > 23. Although [section] 40(c) uses the words "the treatment will be appropriate and effective", it is clear that the legislation is intended to apply to mentally ill individuals whose symptoms cannot be treated or ameliorated in any other way. For the purposes of [section] 40(c) treatment will be "appropriate and effective" if it is treatment directed towards the management of the ill effects of mental illness, or even just the monitoring of a person's mental state: [sections] 6(1)(b) and (d).

  The MHT also commented on section 40(d) and suggested that this criterion will always be met if the criterion in section 40(e) – the person lacks decision-making capacity – is met. This is because a person who lacks decision-making capacity cannot consent to treatment, and as such the only way that a medical practitioner can administer treatment to the person is by way of a Treatment Order.

This suggests that "there are only two treatment criteria": criterion 40(a) – that the person has a mental illness and criterion 40(e) – that the person lacks decision making capacity.

In terms of the treatment criteria, the LACT commented on the meaning of "serious harm". According to the LACT:

> *"It is unclear what constitutes "serious harm" to a person's health or safety or safety of others due to untreated mental illness [section 40(b)]. This phrase in our experience is read down by medical practitioners and the MHT to a question of what "risks" there might be to the person or others. The Act is not a best interest's jurisdiction. Medical practitioners regularly report damage to reputation, untried criminal charges that don't involve harm to others and damage to property as evidence that this treatment criterion is met … These examples, in LACT's view, are not relevant if they do not actually or are likely to cause serious harm to the person's health or safety or the safety of others. The current approach for establishing serious harm erodes the Act's principle of least restrictive intervention and maintaining a person's autonomy to refuse treatment except where there is a clear and pressing serious harm made out".*

The LACT noted that clarity about what is meant by "serious harm" would be helpful in this context.

The LACT also commented on the meaning of treatment as defined in section 6 of the Act and queried whether the reference to reduction of "risk" that persons with mental illness may pose to themselves or others is confusing given the inclusion of the requirement for serious risk in the treatment criteria.

In terms of timeframes for Treatment Orders, one respondent suggested difficulties in meeting time requirements for Treatment Order applications due to unavailability of key administrative staff within the Tasmanian Health Service and MHT after-hours and on weekends.

Several respondents commented on matters to do with the making of Treatment Orders, including as follows:

- One respondent suggested that there should be greater input from the community team when a Treatment Order is sought for an inpatient. The respondent noted that the community team will be required to provide treatment to patients who are subject to Treatment Orders following the patient's discharge from hospital. If the patient is known to be non-contactable or unlocatable, then the patient and community team are "set up to fail". The respondent suggested that in some jurisdictions, community teams are required to confirm that the patient can meet the requirements of a Treatment Order, and that the application is supported by the community team, before a Treatment Order is made.
- The LACT suggested that there is confusion about what "separate assessment" means in subsection 37(4) of the Act. The LACT noted situations where it has been held that a separate assessment carried out at the same time as the first assessment by two clinicians in the same room has been held to be valid. The LACT noted the case of *S v Mental Health Tribunal* where a conversation between a client and a clinician was overheard by another clinician from an office down the hall was upheld on appeal as being a "separate assessment".
- The MHT also referred to the case of *S v Mental Health Tribunal* and expressed the view that while the requirements for applications made for people who are subject to Assessment Orders are well understood by medical practitioners, the requirements for applications made for people who are not subject to Assessment Orders is less well understood. The MHT noted that the requirement for the person to be assessed by the applicant and one other AMP, separately, within the preceding seven days is often problematic.

In relation to interim Treatment Orders:

- A staff member of the Tasmanian Health Service member queried whether interim Treatment Orders should be rendered void if it is not possible for the service to provide the person with immediate treatment, as the respondent stated occurs in Victoria.
- The LACT noted a lack of clarity about whether interim Treatment Orders can be longer than ten days. The LACT noted that where a hearing is commenced but needs to be adjourned, interim Treatment Orders of more than ten days are required. The LACT queried the MHT's capacity to make interim Treatment Orders that exceed ten days and suggested that while subsections 172(2) and (3) would (in the LACT's view) appear to clearly provide for these the MHT's practice is to make interim Treatment Orders for no more than ten days.

In relation to Treatment Orders generally:

- One respondent queried why Treatment Orders need to list the types of medications authorised for the patient. The respondent opined that the use of the Act implies the presence of severe mental illness and in many such cases it would not be uncommon for a patient to need a change to medications. The respondent expressed the view that the requirement to amend a Treatment Order every time a change is required had potential to delay medication changes that would otherwise benefit the patient.
- The Public Guardian (through the Mental Health Act Review Statutory Reference Group) suggested that it would be beneficial for Treatment Orders to specify where a person is to be accommodated, stating that this would address situations where a Treatment Order and Guardianship Order would otherwise be required. The Public Guardian also noted the concept of Treatment Orders specifying supports that a person may require, such as that a person accept care and support. The Public Guardian suggested that this would seem to be capable of happening under subsection 41(5) of the Act. The President of the MHT (also through the Mental Health Act Review Statutory Reference Group) considered the Public Guardian's suggestions but queried how Treatment Orders which specify where a person is to be accommodated would be monitored and compliance ensured. The President also expressed concerns about the potential for a person who is subject to a Treatment Order that applies to accommodation or general support matters "slipping under the radar" in the event the Treatment Order ceases.
- The President of the MHT (through the Mental Health Act Review Statutory Reference Group) observed issues with the fact that Treatment Orders are required to specify a treatment setting and noted that for patients who are admitted to the secure mental health unit this means the Treatment Order is no longer accurate with respect to where the person is being detained.
- The LACT raised several concerns:
    - The LACT noted that anticholinergic medication (medication to reduce the side effects of mental health medication) is routinely included as treatment in Treatment Orders but that the definition of treatment set out in section 6 of the Act does not appear to allow this. The LACT suggested that anticholinergics may more correctly be medical treatments and that clients may have capacity to consent to them particularly if they are raising and/or are distressed by the side effects for which the medications are given and suggested the need for clarification as to whether anticholinergics are treatment, or medical treatment. The definition of treatment and whether it is broad enough to include treatment of physical conditions that are associated with mental illness, and the side effects of the medication or the illness itself (such as malnutrition) was also queried

by the Public Guardian (through the Mental Health Act Review Statutory Reference Group).

- The LACT suggested that the Act is unclear about whether ongoing assessment against the treatment criteria is a part of treatment. The LACT commented that the definition of treatment in section 6 does not mention the word "assessment" but instead refers at subsection 6(1)(d) to the "professional intervention necessary to … monitor and evaluate a person's mental state", which is an assessment-like process. The LACT expressed the view that the ongoing assessment of the nature provided for in section 5 and subsections 6(1)(d) and 27(1)(b) of the Act is a crucial element of ongoing treatment under a Treatment Order however Treatment Orders do not refer to or specifically authorise interventions of this kind.
- The LACT also queried the inclusion in Treatment Orders of a requirement for consumers to undergo illicit drug screening tests.

Several respondents commented on the situation of patients who are subject to Treatment Orders but who cannot be located or contacted and the MHT's practice of continuing to hold hearings in this situation. Several respondents also suggested an understanding that it is necessary for a patient to be seen by his or her treating medical practitioner, or another AMP, before the Treatment Order to which the patient is subject can be discharged, and noted that this requirement is unworkable for patients who have left Tasmania and/or whose whereabouts are unknown.

This feedback was considered alongside feedback from the MHT which suggested some doubt on the MHT's part about whether the MHT has any jurisdiction to review a Treatment Order that has been discharged "irregularly" as the patient is, prima facie, no longer under the Act's jurisdiction.

In terms of the renewal process, respondents provided the following feedback:

- Staff of the Tasmanian Health Service commented on what they understood to be the practice of commencing an application for renewal of a Treatment Order only four weeks prior to the expiry. The respondents suggested that this time frame provides the treating team a window of only 14 days in which to assess patients needing renewal, given the requirement for the application to be lodged with the MHT ten days before the Treatment Order's expiry and that this is problematic as patients do not always attend appointments and it can be difficult to get appointment times with short notice.
- The LACT reported feedback from consumers that towards the end of their Treatment Order, they are not told that they are being assessed by clinicians so that the clinician can apply to renew the Treatment Order and suggested that this makes consumers unhappy. The LACT suggested this was another example of lack of clarity about whether assessment should only be with informed consent or specified in the Treatment Order.
- The MHT reported their view that there is some confusion about the effect of renewing a Treatment Order and whether a renewal results in extension of an existing Treatment Order or the making of a new Order which replaces the existing one. The MHT suggested that this is important because it has implications for mandatory reviews conducted by the Tribunal under subsection 181(1) of the Act.

In terms of failure to comply, respondents provided the following feedback:

- A staff member of the Tasmanian Health Services commented on the options available if section 47 of the Act applies for patients who are living in the community and who comply with the terms of their Treatment Order willingly once they are located by the Crisis Assessment and Treatment Team.

- Another staff member of the Tasmanian Health Services commented on the requirement for a determination under section 47 of the Act to be signed by a medical practitioner and that this makes things awkward for services that don't have ease of access to medical practitioners.
- The MHT suggested that, in practice, medical practitioners infrequently use section 47 and instead prefer to use section 47A of the Act. The MHT suggested that this is because to readmit a patient under section 47A there is no need to demonstrate that a patient is in breach of the Treatment Order and that steps have been taken to ensure compliance. The MHT noted that another reason for this preference may be because reviews of readmissions under section 47A may be conducted by a single member of the MHT, if indicated, on the papers rather than by a panel of three members through a hearing.

In terms of documentation, two respondents provided feedback as follows:

- Staff of the Tasmanian Health Service suggested that the current system of two separate forms for admission for failure to comply under section 47 and to prevent harm under section 47A causes a lot of confusion, as patients on Treatment Orders in the community are long term clients for whom frequent relapses are "part of the overall clinical picture".
- The Southern FLAG noted that copies of key documentation is not always given to patients.

Review Outcome 8:

At least for some people, provisions of the Act for Treatment Orders are not operating effectively nor are they easy to understand and apply.

Reasons for this include a lack of clarity and absence of a shared understand about various matters associated with Treatment Orders including assessment requirements preceding an application being made, the criteria that should apply to be placed on a Treatment Order, the way that Treatment Orders authorise treatment, discharge and renewal, and readmission processes and requirements.

7.3 Special Psychiatric Treatment

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

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

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

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

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

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

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

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

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

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

7.3.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question about special psychiatric treatment, as follows:

- Question 8: Are the special psychiatric treatment provisions of the Act operating effectively? Are they easy to understand and apply?

Only one submission, from the MHT, commented on special psychiatric treatment. The MHT's submission noted that to the best of the Tribunal's knowledge, no special psychiatric treatment has been authorised under the Act.

Review Outcome 9:

No issues with the operation, understanding or application of the special psychiatric treatment provisions of the Act were identified.

7.3.2 Government Response

The Government notes feedback received on the treatment framework established by the Act and on the operation of provisions for Treatment Orders and special psychiatric treatment.

Feedback concerning application of the Act's Treatment Order provisions to forensic patients are addressed in the Government's Response to Review Outcomes 13, 14, 15, 16 and 17.

Government Response to Review Outcomes 7, 8 and 9:

Legislative Response

The Government will amend the Act to retain the requirement for Treatment Plans to be developed and in place for involuntary patients but to change the requirement for a copy of the Plan to be provided to the MHT.

The Government will consider amending the Act to more clearly identify the circumstances in which a person who is in protective custody or subject to an Assessment Order may be provided with treatment.

The Government will amend the urgent circumstances treatment provisions of the Act (sections 55 and 87) to make them clearer and easier to understand and to ensure that they may more clearly be used for a person who has not yet been diagnosed with mental illness or assessed with respect to this.

The Government will amend the Act to clarify whether an interim Treatment Order can be extended by the MHT if a matter is adjourned.

The Government will amend relevant sections of the Act to clarify the matters that must be included in a Treatment Order. As part of this process the Government will consider whether a Treatment Order should refer to types of medications or accommodation. The Government will also consider amendments to clarify "treatment setting" and the circumstances in which a patient may be returned to hospital and the criteria for this.

The Government will amend the Act to clarify how a Treatment Order may be discharged when it is not possible to determine whether the patient meets the treatment criteria because, for example, the patient's location is unknown.

The Government will amend the Act to clarify matters associated with the renewal of Treatment Orders including how long before an Order expires an application for renewal needs to be lodged, whether it should be a requirement for a patient's treating medical practitioner to tell a patient that they are being assessed with respect to an application for renewal and to confirm whether a renewed Treatment Order is a new Order, or an extension of an existing Order.

The Government will consider amending section 16(2) of the Act to confirm that the phrase "with informed consent" includes informed consent provided by a parent under section 9 of the Act and to clarify how parts (i), (ii) and (iii) of the subsection operate to authorise treatment for involuntary patients.

The Government will also consider amending the timeframes associated with applications for Treatment Orders to make them easier for clinicians to meet.

The Government will seek expert legal, clinical and other advice on the need, if any, to amend the Act to clarify what is meant in section 37 by the requirement for the applicant and another approved medical practitioner to have separately assessed the person for whom a Treatment Order is considered to be required.

The Government will also seek expert clinical, legal and other advice to determine whether the Act should be amended to confirm that "treatment" includes anticholinergics, ongoing assessment against the assessment criteria, and a requirement for patients to undergo drug screening tests.

The Government will lastly seek expert clinical, legal and other advice to determine whether the treatment criteria should be amended to remove references to the need for treatment, the appropriateness and effectiveness of the treatment and the risk to the person or others if treatment is not provided. As part of this process the Government will seek advice on whether there is a need to clarify what the terms "serious harm" and "risk" mean, and how the Act can be amended to move away from a "best interests" approach.

Education and Training Response

The Government will develop and deliver education and training to assist clinicians and others to apply the Act's provisions consistently across service settings.

The Government will develop and deliver education and training to assist clinicians and others to understand the circumstances in which a person who is under protective custody or subject to an Assessment Order may be provided with treatment.

The Government will develop and deliver education and training to clarify for clinicians and others when and how urgent circumstances treatment may be authorised and to confirm that this will not always be at the same time as a person is placed on an Assessment Order.

The Government will develop and deliver education and training to support clinicians to write Treatment Plans.

Documentation and Processes Response

The Chief Civil Psychiatrist will review forms for the readmission of patients to approved facilities to ensure that they are clear and easy to understand and complete.

The Chief Civil Psychiatrist will consult with the SHPA to confirm whether the SHPA is aware of the Chief Civil Psychiatrist's Clinical Guideline 7 Off-Label Use of Medications and to see whether the SHPA can suggest any changes that may need to be made to the document to ensure that it is clear and easy to understand, and fit for purpose.

The Tasmanian Health Service will review processes for involuntary patients whose treatment is provided across treatment settings to ensure that community-based members of a patient's treating team are involved in Treatment Order processes at an early point in time and before the patient's discharge to the community.

Resource-Related Response

The Government will consider any funding submissions in relation to this Review Outcome, through future Budget processes.

8. Assessment and Treatment for Children

Under the Act, a child may be treated with informed consent or under an Assessment Order or Treatment Order.

8.1 Assessment and Treatment with Informed Consent

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

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

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

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

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

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

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

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

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

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

For children who are under the guardianship of the Secretary of the Department of Communities Tasmania under the *Children, Young Persons and their Families Act,* decisions about medical treatment may be made by a delegate. Who this will be in practice depends on the type of treatment.

A child who is provided with assessment or treatment with informed consent from a parent has the status of a voluntary patient under the Act. This means that the restrictions and oversight mechanisms that may otherwise be available had the child been an involuntary patient (such as the requirements of the Act associated with regulation of seclusion and restraint, and the ability for a person with standing to apply to the MHT for a review of relevant decisions) do not apply. Instead, the usual rules and protocols applying to the treatment of children in place within the relevant treatment service apply.

8.2 Assessment or Treatment as an Involuntary Patient

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

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

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

- The Act limits the circumstances in which a child may be admitted to and detained in approved hospital to those in which the person or body authorising the admission is satisfied that the relevant hospital has facilities and staff to assess or treat the child and is the most appropriate place to accommodate him or her in the circumstances. Provisions in which this limitation applies include section 27 (relating to Assessment Orders), sections 38, 39, 47 and 47A (relating to Treatment Orders) and section 181 (relating to the MHT's review of Treatment Orders).
- In respect of the admission of an involuntary patient who is a child to a secure mental health unit, section 63 of the Act requires the Chief Forensic Psychiatrist (CFP) to be satisfied that the child can be detained separately from adult patients and that the probable benefits of accommodating the person in the secure mental health unit outweigh the probable risks.
- The Act also requires any authorisation of seclusion or chemical restraint, mechanical restraint or physical restraint for a child to be authorised by the relevant Chief Psychiatrist or a delegate. This essentially limits the decision to authorise seclusion or restraint for a child to an experienced psychiatrist.
- The need to take special care with decisions to seclude or restraint children is emphasised in Chief Civil Psychiatrist and Chief Forensic Psychiatrist Standing Orders 9, 10 and 10A, and in Chief Civil Psychiatrist and Chief Forensic Psychiatrist Clinical Guidelines 9, 10 and 10A relating to seclusion and restraint.
- In respect of the MHT, the Act confirms that a parent of a child is a party to any proceedings concerning the child.

8.3 Treatment in Other Circumstances

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

This is in recognition of existing methods for resolving differences of opinion between parents about whether they should give consent on behalf of a child who lacks decision-making capacity for psychiatric treatment which may, in some cases, require the difference to be resolved through the Family Court or Supreme Court.

Section 219 is intended to resolve any ambiguity about the ongoing role of these Courts in respect of treating that is proposed or given under the Act.

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

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

8.3.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question about assessment and treatment for children:

- Question 9: Is the Act operating effectively to facilitate treatment for children? If not, why do you think this is?

13 of the submissions received addressed the Act's operation as it applies to children.

Several respondents were clear in their view that the Act is not operating effectively to facilitate assessment or treatment for children.

In terms of giving consent to assessment and treatment for a child:

- The Department of Communities Tasmania expressed concern about potential for treatment to be delayed to a young person in circumstances where the child or young person lacks capacity to decide on their own assessment or treatment in circumstances where there is no parent able or willing to provide consent and the young person is not under a guardianship arrangement.
- The Commissioner for Children suggested that in some situations, it is not entirely clear who may provide consent for assessment or treatment for a child who lacks decision-making capacity. Uncertainty may arise where a parent or guardian is unavailable or unwilling to provide consent, where a parent is themselves incapable of providing informed consent, where there is a dispute between parents or between parents and the child about the appropriateness or otherwise of the assessment or treatment proposed, or where the child lives independently and/or is estranged from family.
- The RANZCP Tasmanian Branch stated that it is frequently problematic for a child to be provided with assessment or treatment using informed consent from a parent and thus have the status of a voluntary patient under the Act. According to the Branch, parents are often conflicted, and it is difficult for them to provide appropriate and mutual consent to clinicians. In some instances, the ability for some parents to understand the issues is limited and in situations of "broken families" this can prove problematic and lead to discord and confusion for clinicians.

- The Commissioner for Children noted that while the MHT may make a Treatment Order which provides authority for a child who lacks decision-making capacity to be given treatment without the informed consent of a parent, some practitioners are reluctant to apply to the MHT for a Treatment Order for a child or are uncertain about the process to do so and the Act does not provide explicit guidance for the making of such applications.

In terms of protections available to children under the Act:

- Members of the Southern FLAG expressed the view there are circumstances where children are not protected under the Act.
- The RANZCP Tasmanian Branch also expressed concern about the lack of restrictions and oversight mechanisms for children who are not subject to the Act. The Branch expressed particular concern with respect to children who are subject to restrictive interventions on the basis of consent given by a parent.
- The Commissioner for Children suggested that further consideration should be given to how the Act promotes and protects the rights of children, particularly where they are treated as a voluntary patient but against their wishes.

Several stakeholders including the Commissioner for Children suggested the need to consider whether oversight mechanisms that are available to involuntary patients – for example, in relation to seclusion and restraint – should also extend to children who are being treated as voluntary patients by virtue of parental consent.

The Commissioner for Children observed that provisions of the Act relating to children are scattered throughout the Act and expressed the opinion that it would be beneficial to include a discrete Part in the Act relating to children. The Commissioner expressed the view that this approach would assist readability and clarify the unique considerations which apply when providing services for or carrying out legislative functions relating to children under the Act. This approach would also facilitate the inclusion of a set of guiding principles based on relevant international human rights standards applicable to children, including the *United Nations Convention on the Rights of the Child*.

Stakeholders also questioned the practice of admitting children to adult psychiatric units in circumstances where they are too unwell to be accommodated on a paediatric ward.

Carers Tasmania conveyed the views of carers who were concerned about various aspects of the assessment and treatment of children. Views conveyed included:

- anxiety and anger about being excluded, and fear of clinicians being guided by the perception of a young person who is clouded in their thinking due to the impact of their mental illness
- concern about the capacity for a child to deny access by their parents to the child's medical records
- the extent to which children admitted to paediatric wards are afforded privacy, and
- the difficult situation of children who are vulnerable and do not have family involvement.

Review Outcome 10:

In the view of many, the Act is not operating effectively to facilitate treatment for children.

Reasons for this include difficulties in applying the Act's provisions where there is no parent available or willing to provide consent; lack of clarity around who can provide consent to assessment or treatment for a child who lacks decision-making capacity; lack of oversight available to children who are assessed or treated with the informed consent of a parent; and lack of coherence in the Act's provisions that relate to children.

8.3.2 Government Response

The primary purpose of the Act is to regulate the assessment and treatment of people with mental illness who, because of that illness, lack decision-making capacity to provide consent to assessment and treatment.

The Act determines when a child may be considered to have decision-making capacity for assessment or treatment and enables a parent to give consent on behalf of a child who does not have decision-making capacity.

This reflects the general legal position that applies to children who require health care for a general health condition.

"Parent" is defined broadly in the legislation to mean a person having, for a child, all of the responsibilities which, by law, a parent has in relation to his or her children. This includes biological parents and/or people named in a parenting order made under the Commonwealth *Family Law Act 1975*. The meaning also captures a person who has or who has been granted guardianship of a child, under the *Children, Young Persons and their Families Act 1997*.

For children who are under the guardianship of the Secretary of the Department pursuant to the *Children, Young Persons and their Families Act*, decisions about medical treatment may be made by a delegate. Who this will be in practice, depends on the nature of the treatment that is proposed.

The situation of a child who is considered to require mental health treatment in circumstances where there is support for one parent for this to occur and objection from another parent was considered during the Act's development. The Act was drafted to accommodate existing mechanisms for resolving differences of opinion between parents about whether they should give consent on behalf of a child who lacks decision making capacity, for psychiatric treatment with precisely this situation in mind.

The assumption underlying the Act is that such disputes would be resolved, ultimately, through the Family Court or Supreme Court, following or alongside other mechanisms that would usually be utilised to resolve differences of opinion between parents of children with a general health condition. This intention is reflected in section 219 of the Act.

The Act provides the MHT with the ability to make a Treatment Order for a child who lacks decision-making capacity as an additional means of resolving disputes that may exist.

The Government notes feedback received on the Act's operation with respect to treatment for children and its tenor, which suggests that the approach adopted is deficient in at least some respects.

Government Response to Review Outcome 10:

Legislative Response

The Government will consider amending the Act to make the Act's provisions as they apply to children easier to read and understand. As part of this process the Government will consider amalgamating existing provisions to a new Part that applies specifically to children and developing Mental Health Service Delivery Principles that apply specifically to children.

The Government will consider amending the Act to clarify how a child can be assessed and treated in circumstances where there is no person with parental responsibility willing or able to provide consent.

The Government will consider amending the Act to address the needs of children who are particularly vulnerable. As part of this process the Government will consider mechanisms to mandate the involvement of a child advocate in assessment and treatment decisions.

The Government will seek expert clinical, legal and other advice to determine whether the Act should be amended to either change the status of children for whom consent is given by a parent so that they are no

longer considered "voluntary" or to extend protections that apply to involuntary patients to children who are being assessed or treated with consent from a parent.

Education and Training Response

The Government will develop and deliver education and training to assist clinicians to better understand and apply the Act's provisions as they concern children.

The Government will develop and deliver education and training to support the inclusion of parents in assessment and treatment processes and to ensure that parents are provided with access to relevant documentation.

Documentation and Processes Response

The Government will identify ways to improve processes for ensuring that patients are provided with copies of Assessment Orders, Statements of Rights and other key information.

Resource-Related Response

The Chief Psychiatrists will consider developing a Standing Order or Clinical Guideline explaining the Act's provisions as they apply to children.

9. Involuntary Patient Transfers, Leave and Rights

9.1 Involuntary Patient Transfer Between Approved Hospitals

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

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

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

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

9.2 Involuntary Patient Leave

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

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

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

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

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

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

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

9.3 Absence Without Leave

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

9.3.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question about involuntary patient transfers and leave:

- Question 13: Are provisions of the Act relating to involuntary patient transfers and leaves of absence operating effectively? Are they clear and easy to understand?

Six respondents commented on matters relating to involuntary patient transfers and leave.

The Southern FLAG commented that while provisions for transfers and leave under the Act appear reasonably straightforward and easy to understand, provisions of the Act are often not followed. The Southern FLAG noted that leave options are not always made clear and consumers report that copies of documentation setting out transfer and leave rights are not always supplied even though this is a requirement of the Act. The Southern FLAG also noted reported issues of consumers being denied leave in cases where clinical staff recommended it, and cases where people were being granted leave at times when they were still potentially a danger to themselves. The Southern FLAG opined that this indicates a lack of routine risk assessment.

One staff member of the Tasmanian Health Service expressed the view that provisions of the Act relating to involuntary patient transfers are not operating effectively, that the process is bulky and cumbersome, and that the paperwork needs to be simplified and refined. Another staff member commented on the difficulty of accessing a delegate of the Chief Civil Psychiatrist when transferring a patient out of hours while a third staff member suggesting that transfers between hospitals should be more seamless so that people can be managed in the most appropriate facility rather than only when a transfer is "necessary".

In terms of absence without leave, a staff member of the Tasmanian Health Service noted that the current process requires three forms to be completed while the MHT noted that the Tribunal is not always notified of absence without leave. The Tribunal also reported situations where patients who are absent without leave are discharged from Treatment Orders simply because they can no longer be contacted and suggested that AMPs should not be able to discharge Treatment Orders in these circumstances and without having reviewed the patient.

Review Outcome 11:

While provisions of the Act relating to involuntary patient transfers and leaves of absence are clear and easy to understand they do not always operate effectively.

Reasons for this include staff practices and procedures, the cumbersome nature of the requirements imposed by the Act and (in the case of absence without leave), lack of adequate supporting processes.

9.4 Involuntary Patient Rights

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

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

The Act's objects include to:

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

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

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

- to respect, observe and promote the inherent rights, liberty, dignity, autonomy and self-respect of people with mental illness
- to interfere with or restrict the rights of people with mental illness in the least restrictive way and to the least extent consistent with the protection of those persons, the protection of the public and the proper delivery of the service, and
- to promote the ability of people with mental illness to make their own choices.

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

- The right to be given a written statement that sets out and explains the rights that a patient or prospective patient has in key circumstances (a Statement of Rights), and other important documentation, at various points throughout the patient's assessment and treatment pathway in relevant circumstances.
- The right to ask the CCP to intervene directly regarding the person's assessment, treatment or care. This right is set out in section 147 of the Act.
- The right, as a person with standing, apply to the MHT to review certain matters. These rights are set out in Part 3 Division 2 of the Act.
- The right to receive help from the controlling authority of an approved facility in making an application to the MHT, including through having reasonable access to an Australian lawyer, advocate, translator or other person on whose skills a person may need to rely on to make the application. This right is set out in section 195 of the Act.
- The right to apply to the MHT, as a person with standing, for an Order, determination, direction, or other document to be corrected. This right is set out in section 224A of the Act.
- The right to have information given to him or her in a language or form that the person understands, using an interpreter or alternative augmentative communication system if necessary. This right is set out in section 135 of the Act.
- The right to attend hearings held in proceedings to which the person is a party, and to appear personally or be represented by an Australian legal practitioner, advocate or other person. This right is set out in Schedule 4 Part 2 of the Act.
- The right when attending proceedings before the MHT to be dressed in ordinary (rather than institutional) clothing, as far as this is practicable. This right is set out in Schedule 4 Part 2 of the Act.
- The rights set out in section 62 of the Act.

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

9.4.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question about involuntary patient rights:

- Question 14: Are involuntary patients being afforded the rights referred to in the Act and [the Consultation Document]? If not, why do you think this is?

Seven respondents commented on involuntary patient rights, with only one respondent considering that involuntary patients are being afforded the rights referred to in the Act.

Several respondents commented on involuntary patients not always being provided with Statements of Rights or with copies of key documentation including Assessment Orders. The Southern FLAG also noted that it has been reported that when documentation is given to consumers no effort is made to make sure that the consumer understands or can access the information they have been given.

Respondents also suggested that the rights that patients have under the Act are, at times, not respected and are either ignored, inappropriately applied or incorrectly understood.

One respondent expressed the view that it is difficult to identify the rights that patients have under the Act while other respondents suggested that the Act omits important rights. The Southern FLAG queried the inclusion of provisions in the Act which, in the Southern FLAG's view, void each other and provided the example of provisions which simultaneously do not provide authority for a patient to be placed in seclusion as a means of punishment or for reasons of mere administrative or staff convenience and allow seclusion or restraint to be authorised to provide for the management, good order or security of an approved hospital.

The Southern FLAG referred to the complexity of medio-legal language used in the Act and expressed the view that the Statement of Rights document is not understandable in different situations. The Southern FLAG also commented on the language used in Assessment Orders and Treatment Orders themselves, suggesting that this is difficult for consumers to understand and interpret. The MHT noted that the Act is inconsistent in that forensic patients have additional rights to that of involuntary patients.

The MHT also reported a number of common instances where patients are not afforded the rights under the Act including the use of "back to back" Assessment Orders to detain patients for administrative reasons, patients not being given a copy of the application for Treatment Order, and treatment not being discussed with patients.

Several respondents including the MHT suggested that breaches of rights occur because of ignorance of the Act. The MHT also suggested time constraints and poor resourcing issues as possible causes. Other respondents pointed to the immunity available to practitioners under section 218 of the Act for acts or omissions in good faith as a barrier to accountability.

Advocacy Tasmania noted that some of their clients say that they do not feel their decisions are respected, that they feel judged against a standard of normality that does not reflect their lived experience, and that the system deprives them of access to their usual treating team and supports. They also say it is difficult to build trust and relationships with locum and changing treating teams and that they feel restrictions on their leave and treatment settings are more restrictive than they need to be:

> *"These issues are generally about the operation of the Act, and barriers to rights and protections underpinning the Act translating effectively to those receiving treatment under the Act. Our experience has been that there is often a difference between having a right and being able to enjoy that right in practice".*

Several respondents commented that voluntary consumer rights are "completely absent" from the Act and suggested that this means that the majority of consumers are not covered and often denied access.

One respondent relayed her experience in New Zealand as a Duly Authorised Officer. It was the person's responsibility in this role to contact an independent witness who would attend the treatment setting to

witness the Duly Authorised Officer verbally reading the patient their rights. The witness would sign a specific form and the Duly Authorised Officer would then re-read the patient their rights and sign the paperwork, which was then handed to the patient, with a copy placed on the patient's file. The respondent suggested this system should be brought into Tasmania.

Review Outcome 12:

Involuntary patients are often not being afforded the rights referred to in the Act.

Reasons for this include difficulty in identifying the rights that patients have under the Act, lack of understanding on the part of patients and staff about those rights, staff practices and processes and lack of accountability mechanisms within the legislation for staff to afford patients the rights they are required to be afforded under the legislation.

9.4.2 Government Response

The Government notes feedback received on the extent to which provisions of the Act relating to involuntary patient transfers and leaves of absence are operating effectively and are clear and easy to understand. The Government also notes feedback received on whether involuntary patients are being afforded the rights referred to in the Act.

Issues concerning "back to back" Assessment Orders have been addressed in the Government's response to Review Outcomes 5 and 6.

Issues concerning the ability to for seclusion to be authorised for the management, good order or security of an approved hospital have been addressed in the Government's response to Review Outcome 18.

Matters concerning section 218 of the Act are addressed in the Government's response to Review Outcomes 26, 27, 28 and 29.

Matters concerning the language and form of documentation including Statements of Rights that are required to be provided to patients under the Act are addressed in the Government's Response to Review Outcome 21.

Government Response to Review Outcomes 11 and 12:

Legislative Response

The Government will amend the Act to streamline and simplify leave and patient transfer provisions.

The Government will also consider amending the Act to harmonise involuntary patient rights and forensic patient rights, and to ensure that the rights that are set out in the Act remain contemporary.

Education and Training Response

The Government will develop and deliver education and training to ensure that clinicians and others are aware of the requirement to provide patients with Statements of Rights and copies of relevant documentation, including in respect of leave decisions, at key points in time.

The Government will develop and deliver education and training to support clinicians to conduct risk assessments with respect to decisions to allow involuntary patients to be granted leave, and to take leave that has been granted.

Documentation and Processes Response

The Government will identify ways to ensure that patients are provided with Statements of Rights and copies of other relevant documentation, including in respect of leave decisions, at key points in time.

The Government will review Statements of Rights to ensure that they are understandable in all situations and clearly identify the leave options available to involuntary patients under the Act and the right for involuntary patients to be provided with copies of relevant documentation.

The Chief Civil Psychiatrist will review Chief Civil Psychiatrist Approved Forms relating to leave to reduce and simplify the documentation that needs to be completed when documenting leave.

The Chief Civil Psychiatrist and the Mental Health Tribunal will review documentation associated with Assessment Orders and Treatment Orders respectively to ensure that they are easy for involuntary patients, carers and others to understand and interpret.

Resource-Related Response

The Government will consider any funding submissions in relation to this Review Outcome, through future Budget processes.

10. Forensic Patients

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

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

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

10.1 Admission

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

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

Section 70 of the Act applies to prisoners and youth detainees who have been removed from prison or youth detention to a secure mental health unit on the prisoner or youth detainee's own request.

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

Admission of Involuntary Patients

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

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

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

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

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

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

10.2 Duration of Detention

Forensic Patients Generally

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

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

Prisoners

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

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

Youth Detainees

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

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

Involuntary Patients

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

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

10.2.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question about the admission and detention of people to the secure mental health unit, as follows:

- Question 15: Are provisions for the admission and detention of people to the secure mental health unit operating effectively?

Five respondents provided feedback on this question.

A number of respondents commented on the circumstance of prisoners or detainees who are admitted to the secure mental health unit under authority of section 36A of the *Corrections Act* and who require further assessment or treatment either at the secure mental health unit or in an approved hospital beyond the point that they cease to be a prisoner or detainee (for example, because the person's sentence ends or bail is granted). Feedback received suggested significant confusion about the mechanisms to use to ensure the person's ongoing assessment or treatment and, in appropriate circumstances, admission or re-admission to the secure mental health unit or other health facility, and the extent to which the Act provides flexibility in this regard.

The MHT also noted that it has experienced difficulty in holding mandatory 60- and 180-day reviews of Treatment Orders for prisoners at Risdon Prison. The MHT noted there is no video link and in practice prisoners are given the time for the hearing and taken to a telephone for the hearing link up. If the MHT is running overtime on other hearings the prisoner is unable to wait by the phone for the hearing to commence. The MHT commented that in their view, this is a denial of natural justice to appear at their hearing.

The MHT further commented on what it described as insufficient resources to have prisoners on Treatment Orders regularly reviewed by psychiatrists.

A number of respondents also commented on the circumstance of involuntary patients who are admitted to the secure mental health unit under authority of section 63 of the Act:

- RANZCP Tasmanian Branch expressed the view that the "interface between forensic and civil beds fundamentally causes problems" and queried whether section 63 should be removed, apparently on the basis of a view that transferring civil patients to the forensic arena is out of step with modern practice. The Branch also suggested the need to also review the legal pathway for youth detainees to be transferred to the secure mental health unit.
- The MHT noted that section 63 is confusing and queried why a patient can only be admitted to the secure mental health unit from an approved facility and whether a person who is already in the secure mental health unit can be re-admitted to the unit without being transferred out to facilitate the re-admission process. The MHT noted further confusion about the status of involuntary patients and suggested that the person's involuntary patient status should not change as they move through the assessment and treatment pathways. This is relevant because it has been argued that authorisation for a person's admission to the secure mental health unit ceases once any Assessment Order or interim Treatment Order to which they are subject ceases.

The Public Guardian (through the Mental Health Act Review Statutory Reference Group) queried whether there could be flexibility for the Chief Psychiatrists to make varied arrangements (being arrangements that are not provided for under section 63 of the Act) for the readmission of involuntary patients to the secure mental health unit in special circumstances.

Some respondents also queried whether the secure mental health unit could be made an approved hospital as a possible way of overcoming these difficulties.

The MHT noted that there are considerable drafting inconsistencies between provisions for the admission and custody of forensic patients and provisions for the assessment and treatment of involuntary patients and suggested that consideration should be given to harmonising terminology and treatment pathways to avoid confusion.

The ACMHN Tasmanian Branch suggested that provisions for the admission and detention of people to the secure mental health unit are adequate but that there are operational limitations in the context of bed availability. The Branch's comments suggested that lack of beds in the secure mental health unit delays commencement of treatment which can impact on staff attempting to manage the behaviour of patients who are prisoners within the prison environment.

Review Outcome 13:

Provisions for the admission and detention of people to the secure mental health unit are not operating effectively in all cases.

The main reason for this is lack of clarity in the Act's provisions.

10.3 Forensic Patient Movements and Forensic Patient Leave

Transfer Between Secure Mental Health Units

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

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

Transfer to Hospital Etc

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

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

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

Return of Patients to Secure Mental Health Units

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

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

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

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

Leave of Absence

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

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

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

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

Attendance at Court

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

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

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

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

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

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

Leave for Forensic Patients Subject to Restriction Orders

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

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

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

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

- The MHT is to notify the Secretary (Corrections) of the application. The Secretary (Corrections) is then to check the Eligible Persons Register to determine whether there are any eligible persons (registered victims) in relation to the patient. If there are, the Secretary (Corrections) is required to make a reasonable attempt to notify each eligible person of the application and of their right to make written submissions in respect of it. Each eligible person then has ten days in which to make a submission.
- The MHT is to notify any other person who the MHT thinks should be told about the application and of that person's right to make written submission in respect of it. Any person notified in this way then has ten days in which to make a submission.
- The MHT is to consider any submissions received before granting or refusing to grant the request for leave.

The MHT can grant leave for a particular purpose, for a specified period, or for a particular purpose and period. If leave is granted for a particular purpose without a period being specified, then the period may be determined by the CFP.

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

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

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

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

Leave for Forensic Patients Not Subject to Restriction Orders

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

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

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

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

- If the patient is a prisoner or detainee under the Corrections Act, the CFP is to notify the Director, Corrective Services of the application and of the Director's right to make a written submission in respect of the application. The Director then has ten days in which to make a submission.
- If the person is a youth detainee, the CFP is to notify the Secretary (Youth Justice) of the application and of the Secretary's right to make a written submission in respect of it. The Director then has ten days in which to make a submission. The CFP is also to check whether the Secretary consents to the application. This is relevant because the CFP may only grant leave to a person who is a youth detainee if the Secretary consents.
- The CFP is to notify any other person who the CFP thinks should be told about the application and of that person's right to make written submission in respect of it. Any person notified in this way then has ten days in which to make a submission.
- The CFP is to consider any submissions received before granting or refusing to grant the request for leave.

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

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

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

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

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

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

Notice to Eligible Persons

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

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

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

These obligations do not apply to involuntary patients who have been admitted to a secure mental health unit under section 63 of the Act for the reasons outlined above.

The Act also makes it a requirement under section 119 of the Act for the controlling authority of a secure mental health unit to notify the Secretary (Corrections) when a forensic patient is finally released from a secure mental health unit (or transferred to another secure mental health unit). This is to enable the Secretary (Corrections) to search the eligible persons register and let each eligible person in relation to the forensic patient know of his or her release or transfer.

10.3.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question about forensic patient movements, as follows:

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

Five respondents provided feedback on this question. Each of the submissions focussed on patient leave arrangements.

Many respondents provided feedback suggesting that the provisions of the Act for forensic patient leave are operating effectively, and that the processes for having leave granted are working well. Feedback received suggested issues however with the Tasmanian Health Service's capacity to facilitate leave that has been granted.

One respondent suggested problems with therapeutic leave, which in the respondent's view takes second place to Court and medical leaves. The respondent noted resource problems relating to trained staff and cars. These sentiments were echoed by the MHT, which suggested that leave that is authorised by the Tribunal for forensic patients from the secure mental health unit is often cancelled due to poor staffing and resourcing levels, and by Carers Tasmania, which noted a perception that leave due to staff shortages results in limited opportunity for rehabilitation, creating institutionalisation and prolonging incarceration and reduced opportunity for a "meaningful life following discharge".

The respondent also noted transitional problems as in when one leave program ends there is a gap of no leave for a period of months before the next program begins. This is important because lack of progression in leave impacts on the ability for patients to be successful in seeking discharge from the secure mental health unit.

Carers Tasmania reported feedback from carers who felt that their perspectives or suggestions regarding potential opportunities for rehabilitation were "not truly heard" in MHT forensic patient leave processes. In the case of long-term forensic patients, Carers Tasmania expressed the view that this lack of being truly heard over several years results in families feeling disempowered and ill-equipped to move forward post-discharge.

Review Outcome 14:

Provisions for forensic patient movements and forensic patient leave are generally operating effectively and efficiently and are clear and easy to understand.

Resourcing, and the capacity for therapeutic and rehabilitation leave to be granted and prioritised, are issues for at least some forensic patients and their families.

10.4 Forensic Patient Treatment

Treatment under a Treatment Order

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

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

Authorisation of Treatment by the Tribunal

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

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

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

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

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

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

Interim Authorisation of Treatment

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

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

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

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

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

Authorisation Becomes a Treatment Order

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

10.4.1 Consultation Questions, Feedback Received and Review Outcome

The Document asked one question about forensic patient treatment, as follows:

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

Four respondents provided feedback in response to this question.

Carers Tasmania provided feedback from carers about the clinical support provided by psychologists, and the role of social workers, in terms of forensic patient treatment.

Carers Tasmania conveyed feedback from carers to the effect that carers were of the understanding that any clinical support provided by a psychologist from mental health services can be used in the setting of the MHT, effectively meaning the forensic patient has no confidential space, an important part of the therapeutic relationship.

Carers Tasmania also conveyed feedback from carers that while social workers are available in the forensic setting, they are not perceived to be fully supporting the person they care for in the context of making decisions for their longer-term future (such as financial management and the purchase of property). As a result, these matters are left to family who are already under immense strain, or are ignored, potentially reducing options for financial security and secure accommodation in the future.

Two respondents raised concerns about the treatment of prisoners who are under the Act. A staff member of the Tasmanian Health Service suggested that there is confusion about the treatment of prisoners who are under the Act and that more education is required. The RANZCP Tasmanian Branch queried whether the Act applied to people in prison and whether treatment that is authorised for a prisoner by way of a Treatment Order can be given immediately following the prisoner's transfer to the Wilfred Lopes Centre rather than by seeking further approval from the MHT – that is, whether Treatment Orders transpose seamlessly on transfer.

The RANZCP Tasmanian Branch also noted concerns about the interface between involuntary treatment and restriction orders. The Branch noted that most restriction order declarations are the result of the Supreme Court deciding that "psychotic disorder was the driving force" for a serious offence and questioned whether the law should be "reconstructed" such that restriction orders automatically allow for treatment of mental disorder rather than if and when such treatment is refused. The Branch's submission appeared to suggest that this would overcome scenarios in which forensic patients subject to restriction orders have or regain decision-making capacity in which case treatment may either be interrupted or stopped.

Review Outcome 15:

Provisions for the treatment of forensic patients are generally operating effectively and efficiently and are clear and easy to understand.

Issues exist with respect to the treatment of people who are prisoners and for at least some stakeholders, the interface between involuntary treatment and restriction orders is problematic.

10.5 Forensic Patient Management

Use of Force

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

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

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

Force is only to be used by a member of secure mental health unit staff, a medical practitioner, a nurse, an authorised person or a person who has or is entitled to take immediate lawful custody of the forensic patient, or an assistant of one or more of these people.

The force used may be no more excessive, unusual or prolonged than is reasonably justified in the circumstances and in no case may force be applied as a means of punishment or for reasons of administrative or staff convenience.

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

Entry of Items to the Secure Mental Health Unit

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

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

Screens and Searches

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

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

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

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

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

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

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

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

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

10.5.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question about the operation of provisions for the management of forensic patients and the secure mental health unit:

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

One respondent (Carers Tasmania) provided feedback on this question. Carers Tasmania reported feedback that had been received from two people that Carers Tasmania spoke to during the consultation, as follows:

- one person expressed concern about the privatisation of some services, such as security, which (in the person's view) may "water down" the need to apply the Mental Health Service Delivery Principles in the performance of relevant functions, and
- another person commented on the "risk averse" nature of the care that is provided to forensic patients with significant history and expressed concern that such an approach does not give patients the opportunity to learn new skills, or maintain or build relationships important to recovery, or demonstrate them, potentially resulting in institutionalisation or isolation. This, coupled with limited access to leave due to staff shortages, was perceived to be resulting in limited opportunity for rehabilitation and for a meaningful life following discharge. This has a consequent impact on family relationships, where the only time a family member can spend with their loved one is in a "prison-like" environment. In cases of serious forensic history, where family relationships are likely to experience significant strain, not being able to spend time together in a "normal" environment is a loss, and over the period of years, can result in fracturing of family relationships.

Review Outcome 16:

Provisions for the management of forensic patients and the secure mental health unit are operating effectively and efficiently and are clear and easy to understand.

For at least some people, the privatisation of security services and the way in which risk is managed as part of the care that is provided to forensic patients with significant history are issues.

10.6 Forensic Patient Rights

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

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

The Act's objects include to:

- provide for the assessment and treatment of people with mental illness to be given in the least restrictive setting consistent with clinical need, legal and judicial constraints, public safety and patient health, safety and welfare, and
- promote voluntary over involuntary assessment and treatment and the making of free and informed assessment and treatment choices.

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

- respect, observe and promote the inherent rights, liberty, dignity, autonomy and self-respect of people with mental illness
- interfere with or restrict the rights of people with mental illness in the least restrictive way and to the least extent consistent with the protection of those persons, the protection of the public and the proper delivery of the service, and
- promote the ability of people with mental illness to make their own choices.

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

- The visiting, telephone and correspondence rights set out in sections 97 – 107 of the Act.
- The right to be given a written statement that set out and explains the rights that a forensic patient has in key circumstances (a Statement of Rights), and other important documentation, at various points throughout the patient's admission and treatment pathway.
- The right to ask the CFP to intervene directly regarding the patient's assessment, treatment or care. This right is set out in section 147 of the Act.
- The right, as a person with standing, apply to the MHT to review certain matters. These rights are set out in Part 3 Division 2 of the Act.
- The right to apply to the MHT, as a person with standing, for an Order, determination, direction, or other document to be corrected. This right is set out in section 224A of the Act.
- The right to have information given to him or her in a language or form that the person understands, using an interpreter or alternative augmentative communication system if necessary. This right is set out in section 135 of the Act.
- The further rights set out in section 108 of the Act.

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

10.6.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question about the operation of provisions for forensic patient rights, as follows:

- Question 19: Are forensic patients being afforded the rights referred to in the Act and [the Consultation Document]? If not, why do you think this is?

Two respondents commented on forensic patient rights specifically. Both respondents confirmed that in their view, forensic patients are being afforded the rights referred to in the Act and Consultation Document.

One respondent queried whether there should be capacity in the Act for patient telephone calls to be monitored in real time.

Review Outcome 17:

Forensic patients are being afforded the rights referred to in the Act.

10.6.2 Government Response

The Government notes feedback received on operation of provisions in the Act concerning the admission, detention, movement, treatment and management of forensic patient, and regulating forensic patient leave.

Concerns from carers about not being "truly heard" in MHT forensic patient leave processes are addressed in the Government's Response to Review Outcomes 22 and 23.

Government Response to Review Outcomes 13, 14, 15, 16 and 17:

Legislative Response

The Government will amend the Act to clarify and streamline admission and discharge mechanisms for prisoners and detainees, and youth detainees, requiring admission to or discharge from a secure mental health unit. As part of this process the Government will consider the need for amendments to intersecting legislation including the *Corrections Act 1997* and *Youth Justice Act 1997*. The Government will also consider the need for amendments to clarify the Act's provisions as they concern prisoners and detainees, and youth detainees, and people who are discharged from prison or youth detention.

The Government will also amend the Act to clarify and streamline admission, re-admission, detention and discharge mechanisms for involuntary patients requiring admission (or re-admission) to, or discharge from, a secure mental health unit.

The Government will consider amendments to the Act to harmonise terminology and treatment pathways that apply to involuntary patients and forensic patients.

The Government will consider any amendments to the criteria for treatment for forensic patients set out in the Act as part of the Government's consideration of the TLRI's Final Report following the TLRI's review of the Defence of Insanity in section 16 of the *Criminal Code Act 1924* and fitness to plead.

The Government will seek expert clinical, legal and other advice to determine whether the Act should be amended to provide authority for telephone calls made to or from forensic patients to be monitored.

Education and Training Response

The Government will develop and deliver education and training to assist clinicians to better understand and apply the Act's provisions as they concern prisoners.

The Government will develop and deliver education and training to support clinicians to conduct risk assessments with respect to decisions to allow forensic patients to take leave that has been granted.

The Government will also develop and deliver education and training to assist carers to better understand the role and function of all members of a forensic patient's treating team.

Documentation and Processes Response

The Government will review processes for the conduct of reviews of patients who are subject to Treatment Orders and who are detained, at the time of the review, in prison.

The Government will review processes for forensic patient leave programs to ensure continuity of leave programs and to ensure that patients who have been granted leave can take it to the maximum extent possible in the circumstances.

The security procedures in place at the Wilfred Lopes Centre were reviewed by the Tasmanian Health Service in 2019 as part of the Government's response to the Prisoner Mental Health Care Taskforce Final Report and found to be appropriate. No further action is considered to be required.

Resource-Related Response

The Government will consider any funding submissions in relation to this Review Outcome, through future Budget processes.

11. Seclusion and Restraint

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

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

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

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

The following Clinical Guidelines have also been issued:

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

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

The Chief Psychiatrists' Standing Orders and Clinical Guidelines can be found online here: www.dhhs.tas.gov.au/mentalhealth/mental_health_act/mental_health_act_2013_new_mental_health_act/clinical_guidelines_and_standing_orders

11.1 Seclusion

The Act defines seclusion to mean:

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

Authorisation of Seclusion

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

- Under section 56 of the Act, an involuntary patient may only be placed in seclusion if the person is in an approved hospital and if:
    - the seclusion is authorised as being necessary to facilitate the person's treatment, to ensure the person's health or safety, to ensure the safety of other people or to provide for the management, good order or security of the approved hospital
    - the seclusion is authorised by:
        - if the person is a child, the CCP or a delegate
        - if the person is an adult, the CCP or a delegate, or a medical practitioner, or an approved nurse
    - the person authorising the seclusion is satisfied that it is a reasonable intervention in the circumstances, and
    - the seclusion lasts for no longer than has been authorised.
- Under section 94 of the Act, a forensic patient may only be placed in seclusion if:
    - the seclusion is authorised as being necessary to facilitate the person's treatment or general health care, to ensure the person's health or safety or the safety of others, to prevent the person from destroying or damaging property, to prevent the person's escape from lawful custody, to provide for the management, good order or security of the secure mental health unit, to facilitate the person's lawful transfer to or from another facility, whether in Tasmania or elsewhere, or for a reason sanctioned by Chief Forensic Psychiatrist Standing Orders
    - the seclusion is authorised by:
        - if the person is a child, the CFP or a delegate
        - if the person is an adult, the CFP or a delegate, or a medical practitioner, or an approved nurse
    - the person authorising the seclusion is satisfied that it is a reasonable intervention in the circumstances, and
    - the seclusion lasts for no longer than has been authorised.

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

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

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

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

Duration of Seclusion

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

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

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

11.2 Restraint

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

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

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

Authorisation of Restraint

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

- Under section 57 of the Act, an involuntary patient may only be placed under restraint if the patient is in an approved assessment centre or approved hospital and if:
    - the restraint is authorised as being necessary to facilitate the person's treatment, to ensure the person's health or safety, to ensure the safety of other people or to bring about the person's transfer to another facility
    - the restraint is authorised by:
        - if the restraint is chemical restraint or mechanical restraint, the CCP or a delegate
        - if the restraint is physical restraint and the person is a child, the CCP or a delegate
        - if the restraint is physical restraint and the person is an adult, the CCP or a delegate, or a medical practitioner, or an approved nurse
    - the person authorising the restraint is satisfied that it is a reasonable intervention in the circumstances
    - the restraint lasts for no longer than has been authorised, and
    - if the restraint is mechanical restraint, the means of restraint to be used has been approved in advance by the CCP.
- Under section 95 of the Act, a forensic patient may only be placed under restraint if:
    - the restraint is authorised as being necessary to facilitate the patient's treatment or general health care, to ensure the patient's health or safety or the safety of others, to prevent the patient from destroying or damaging property, to prevent the patient's escape from lawful custody, to provide for the management, good order or security of the secure mental health unit, to facilitate the patient's lawful transfer to or from another facility, or for a reason sanctioned by Chief Forensic Psychiatrist Standing Orders
    - the restraint is authorised by:
        - if the restraint is chemical restraint or mechanical restraint, the CFP or a delegate
        - if the restraint is physical restraint and the person is a child, the CFP or a delegate,
        - if the restraint is physical restraint and the person is a child, the CFP or a delegate, or a medical practitioner, or an approved nurse
    - the person authorising the restraint is satisfied that it is a reasonable intervention in the circumstances

- the restraint lasts for no longer than has been authorised, and
- if the restraint is mechanical restraint, the means of restraint to be used has been approved in advance by the CFP.

The former Chief Civil Psychiatrist Dr Leonard Lambeth approved the use of "Posey" brand restraint cuffs, model number JT Posey REF 2790 L9118M, and restraint cuffs that are of a similar style and quality, as means of restraint which may be employed in specific cases of mechanical restraint under and for the purposes of section 57 of the Act on 14 February 2014. The approval took effect on 17 February 2014 and remains in place.

The then Acting Chief Forensic Psychiatrist Professor Ken Kirkby approved the use of Hiatts handcuffs serial number 241092 and Smith & Wesson handcuffs serial numbers P11302 and P66374 as means of restraint which may be employed in specific cases of mechanical restraint under and for the purposes of section 95 of the Act on 5 June 2018. The approval remains in place.

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

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

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

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

Duration of Restraint

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

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

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

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

11.3 Matters in Common

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

Observation and Examination Requirements

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

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

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

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

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

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

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

11.4 Emergency Short-Term Restraint

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

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

11.4.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question with respect to the operation of the seclusion and restraint provisions of the Act, as follows:

- Question 20: Are the seclusion and restraint provisions of the Act operating effectively and efficiently?

12 of the submissions received commented on the seclusion and restraint provisions of the Act.

Feedback received suggested that the seclusion and restraint provisions are not operating effectively or efficiently.

The Southern and Northern FLAGs provided feedback suggesting that patients report that they are being secluded or restrained to compensate for or overcome inadequate facility design or insufficient staffing, for staff convenience and as a form of punishment. The Southern FLAG also noted feedback suggesting that the observation and other timeframes set out in the Act for seclusion and restraint are not being adhered to. Another respondent suggested more clearly defining what amounts of "breaching the good order of the ward" in Standing Orders and Clinical Guidelines.

A few respondents commented on the perception that the rights provided for in the seclusion and restraint provisions are "cancelled out" by a later clause. To this end the Southern FLAG noted that under the Act, seclusion and restraint cannot be used for staff convenience or punishment but still be authorised for the good management of the ward.

Several respondents commented specifically on the impact of facility design and associated matters on the use of the seclusion and restraint provisions. The Northern FLAG commented on the intimidating nature of the "HD" room while a staff member of the Tasmanian Health Service talked about the use of canvas blankets, suggesting they be replaced with cotton blankets.

The Southern FLAG questioned whether regulating chemical and mechanical restraint through the Act has reduced the use of these practices. The Southern FLAG suggested banning the practices and making it clear that all use of such practices be considered "malpractice". The proposal to ban these types of restraint was specifically supported by one other correspondent. Both respondents made similar comments about the use of seclusion.

Several respondents also commented on the impact of staffing and staffing practices on the use of seclusion and restraint provisions and the sufficiency of risk assessments that are conducted with respect to patients who are suicidal and secluded.

Several respondents commented on the use of security guards and orderlies to assist with restraint and questioned this practice.

Several respondents commented on reporting of seclusion and restraint with one respondent noting, as an example, the practice of recording multiple episodes of seclusion as a single episode and another commenting that chemical restraint is seldom reported. The respondent identified lack of understanding on the part of clinicians about when a person is secluded and the difference between the use of a patient's medication and the use of medication to specifically control a patient's behaviour, despite the Chief Psychiatrists' Clinical Guidelines explaining the difference, as a possible source of this difficulty.

Two respondents commented on seclusion and restraint within the context of OPCAT and queried whether seclusion and restraint would be considered practices that are prevented under the Convention. The Southern FLAG suggested the need to review existing practices given Australia's ratification of OPCAT.

Several respondents provided feedback on the terms of the provisions in the Act for seclusion and restraint, suggesting that the provisions are confusing and difficult to understand.

Two respondents commented on the paperwork for seclusion and restraint, suggesting that it is repetitive and onerous. One respondent, a staff member of the Tasmanian Health Service, commented that "good documentation done once is better than poor documentation copied many times in many places" and suggested that a pathway type document is developed that allows staff to comprehensively document all the required information in one document. The respondent suggested that this would lead to less information being missed and better adherence to the Act and would make for easier auditing and review of seclusion and restraint events.

Several respondents commented on the Act's scope with respect to short-term physical restraint. For example:

- One respondent suggested that the definition of psychical restraint needs to be redefined to better reflect best practice within inpatient mental health settings. The respondent suggested that the time spent on recording short instances of physical restraint could be better spent on building therapeutic relationships with patients and that physical restraint should only be applicable where approved force is required to administer medication, or a violent patient needs to be restrained to prevent injury.
- Other respondents suggested that restraints in the Emergency Department are not being recorded due to lack of staff that have the authority to restrain and instead they are using duty of care. The respondents suggested this could be resolved if any registered nurse could authorise restraint for a period of four to six hours.

Two respondents commented specifically on the need for more face to face education and training. The need for more training to ensure that seclusion and restraint is properly authorised was also highlighted by the MHT.

Review Outcome 18:

The seclusion and restraint provisions of the Act are not operating effectively and efficiently.

Reasons for this include lack of clarity in the Act's provisions, inadequate facility design, and lack of clear understanding about the Act's requirements with respect to seclusion and restraint.

11.4.2 Government Response

The Government notes feedback received on the operation of the seclusion and restraint provisions of the Act.

Matters concerning section 218 of the Act are addressed in the Government's response to Review Outcomes 26, 27, 28 and 29.

Government Response to Review Outcome 18:

Legislative Response

The Government will amend the Act to streamline the seclusion and restraint provisions to make them easier to understand and more consistent with other provisions of the Act. As part of this process the Government will consider amendments to remove the ability for a person to be secluded to provide for the management, good order or security of an approved hospital.

The Government will also amend the Act to clarify the use of short-term physical restraint and to distinguish this from physical restraint that is required to be authorised under and regulated by the Act. As part of this process the Government will seek expert clinical, legal and other advice on the need for amendments to the Act to regulate the use of force/short term restraint with respect to people who are in protective custody and/or restrained for "duty of care" type reasons.

The Government will consider amendments to either prevent or more closely regulate the use of mechanical or chemical restraint and to reduce the use of seclusion in approved facilities.

Education and Training Response

The Government will develop and deliver education and training to assist clinicians and others to better understand and apply the Act's provisions as they concern seclusion and restraint, including the observation and other timeframes that apply and record keeping requirements.

The Government will develop and deliver education and training to support clinicians to distinguish between chemical restraint and treatment, and to conduct risk assessments with respect to patients who are in suicidal distress and who are considered to require seclusion or restraint.

Documentation and Processes Response

The Government will replace canvas blankets used in seclusion rooms with cotton blankets. The Government will also consider alternatives to the use of security guards and orderlies to assist with restraint.

The Chief Psychiatrists will amend those of the Chief Psychiatrists' Standing Orders and Clinical Guidelines that apply to restraint to more clearly distinguish chemical restraint from treatment.

The Chief Psychiatrists will also review and revise the Chief Psychiatrists' Approved Forms for seclusion and restraint to make them less repetitive and onerous to complete, particularly in situations where a person is both secluded and restrained.

Resource-Related Response

The Government will consider any funding submissions in relation to this Review Outcome, through future Budget processes.

12. Protective Custody and Patient Escort

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

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

The Custody and Escort Provisions set out in Schedule 2 of the Act apply to any exercise of protective custody and escort functions.

12.1 Protective Custody

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

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

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

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

Examination by a Medical Practitioner

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

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

Handover

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

An MHO or police officer who takes a person into protective custody to an approved assessment centre may ask any MHO at the approved assessment centre to take over the person's custody. Under section 18

of the Act an MHO at the approved assessment centre who is asked to take over custody in this manner to comply with the request, unless it would be unsafe in the circumstances to do so.

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

Release

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

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

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

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

12.2 Patient Escort

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

Handover

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

12.3 Matters in Common

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

Custody and Escort Policy

Schedule 2 of the Act provides that, as far as practicable:

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

General Powers

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

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

Search Powers

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

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

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

Identification Requirements

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

12.3.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question with respect to the protective custody and patient escort provisions, as follows:

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

14 respondents provided feedback in response to this question.

Several respondents commented on the use of protective custody in the context of Emergency Departments:

- Staff of the Tasmanian Health Service provided feedback on the capacity for people who have presented at Emergency Departments voluntarily to be taken into protective custody. Staff noted the importance of being able to take people who are not in protective custody on arrival at an approved assessment centre into protective custody to mitigate risk and queried the capacity to do this in light of subsection 18(1)(a) of the Act, which requires an MHO or police officer who has a person in protective custody to escort the person to an approved assessment centre, subsection 19(1) of the Act, which indicates that section 19 applies if a person taken into protective custody has been escorted an approved assessment centre only, and the absence of any clear indication in the Act that an MHO has the power to take a person into protective custody if the person is not in protective custody on arrival at the facility.
- Tasmania Police noted they often experience difficulty in handing over custody of people at hospitals. The Act requires an MHO who is asked to take over a person's protective custody at a hospital to comply with the request unless it would be unsafe in the circumstances to do so. According to Tasmania Police, hospital staff have claimed that it is unsafe to take custody of mental health patients due to staffing levels, when in Tasmania Police's view the aim of the section was that it would be unsafe if the patient was violent and needed police to maintain control. The necessity for police to spend long periods of time at hospitals with patients causes a further issue of lack of safety in the community in general, due to the lack of availability of police.
- The ACMHN Tasmanian Branch raised concerns about the safety of the protective custody and the lack of awareness of the process on the part of clinicians and consumers. The Branch reported poor adherence to the process especially when the four-hour period expires and in respect of the handover process, and the required paperwork. The Branch also raised safety-related concerns about the situation when the consumer becomes voluntary and is still acutely unwell.

Several respondents commented specifically on the requirement for protective custody to cease after four hours of a person's arrival at an approved assessment centre, as follows:

- Carers Tasmania suggested that a period of time longer than four hours might give more scope for a person to be taken into custody (to allow more time for police change of shifts, resource challenges, locating the person) or for assessment to occur in hospital, where resources are stretched.
- Staff of the Tasmanian Health Service suggested that four hours is not long enough to be seen once the patient arrives at an approved assessment and suggested allowing six hours for this to occur.
- The Southern FLAG noted that in their understanding, the clock for an assessment starts from the moment a consumer is taken into protective custody. An assessment is required to take place by law within four hours, and if it does not then the person who was brought in under protective custody must be released. The Southern FLAG suggested that this leads to people who need treatment being released without seeing a doctor and may be contributing to an "over-use" of urgent circumstances treatment.
- The RANZCP Tasmanian Branch also noted problems that registrars have highlighted with the four-hour time frame required under section 19 of the Act. The Branch noted that in an ideal world, the four-hour time frame would probably be adequate, but the experience of clinicians is that a slightly longer period is required as a result of difficulties within the Tasmanian Health Service. The Branch commented that registrars have provided numerous examples where the four-hour time period has elapsed and there appears to be no reasonable prospect in the future of these problems being resolved. The RANZCP suggested that the alternative is to extend the time allowed by the Act for

protective custody. According to the Branch, this will not compromise patient rights but improve the ability to meet any timeframe for assessment under the Act and assist patient safety as it prevents expiry of protective custody and the risks that may ensue if a patient decides to self-discharge.

In terms of the custody and escort policy set out in Schedule 2 of the Act:

- Tasmania Police noted the custody and escort policy which provides that, wherever practicable, the use of non-police custodians, escorts and assistants is to be preferred and submitted that the policy objectives are not being adhered to on a regular basis, and that police are being routinely used as first responders and escorts of people with mental health issues.
- Staff of the Tasmanian Health Service expressed the view that patients in protective custody are frequently restrained in Emergency Departments with no oversight of the restraint, because the Act "deems it to be reasonable force". Staff expressed the view that patients under protective custody should have the same right of review as patients on Assessment Orders and that all restraints of patients within the assessment centre should need the same approvals and paperwork. Staff went onto suggest that this would make it less confusing for Emergency Department staff and would give a "truer picture" of the amount of restraint that occurs.
- With reference to the use of force under the custody and escort provisions, Advocacy Tasmania conveyed provided feedback from a consumer suggesting that use of handcuffs by police when dealing with mental health patients should not be permitted.

In terms of resourcing, staff of the Tasmanian Health Service highlighted resourcing implications of requiring escort by an MHO or police officer in relevant circumstances. Staff noted that some parts of the Tasmanian Health Service have limited staff who are approved MHOs and commented on the impact of delays associated with waiting for an MHO or other person to take a person into protective custody on the person's mental state.

In terms of education and training, one respondent noted incidences where a person has been taken into protective custody where the requirements for that custody were not met. The respondent noted that the provisions for protective custody seem straightforward and suggested that the apparent failure to apply them correctly seem to relate more to a lack of knowledge and procedure than the provisions themselves.

In terms of documentation requirements, the Southern FLAG submission noted that consumers have reported that they are not being given a record of their custody and the treatment they received.

Review Outcome 19:

The protective custody and escort components of the Act do not always operate effectively nor are they always clear and easy to understand. In particular, and for at least some people, the time period in which a person may be held in protective custody following arrival at an approved assessment centre is too short.

Reasons underpinning the reported ineffective operation of the provisions include lack of clarity in the Act's provisions, lack of understanding on the part of at least some people about the Act's provisions and requirements, and inadequate resourcing.

12.3.2 Government Response

The Government notes feedback received on the extent to which the protective custody and escort components of the Act are operating effectively, and about how clear and easy they are to understand. \

Matters concerning the use of force and/or restraint with respect to people who are in protective custody, or for "duty of care" type reasons, have been addressed in the Government Response to Review Outcome 18.

Government Response to Review Outcome 19:

Legislative Response

The Government will review and amend the protective custody provisions in the Act to make them more readily applicable to people who are already at an approved assessment centre when the need to take the person into protective custody becomes apparent.

The Government will seek expert clinical, legal and other advice on the need to amend the Act to alter the time for which a person who has been brought to an approved assessment centre in protective custody may be held at the centre.

Education and Training Response

The Government will develop and deliver education and training to assist clinicians to better understand and apply the Act's provisions as they concern protective custody and escort functions. Education and training that is developed and delivered will clarify the obligation for MHOs who are based in Emergency Departments to comply with requests from police officers and other MHOs to accept the protective custody of a person where that custody is handed over, in relevant circumstances. Education and training will also clarify the requirement to release a person from protective custody after four (4) hours and provide guidance on the steps that should be taken to address the situation of people who are unwell when they are released from protective custody.

Documentation and Processes Response

The Tasmanian Health Service will review processes surrounding protective custody to ensure that police officers are not used routinely as "first responders" and escorts of people with mental illness.

The Tasmanian Health Service will also review processes surrounding the handover of protective custody to ensure that police officers can hand over a person's protective custody in a timely manner when this is required.

Resource-Related Response

The Tasmanian Health Service will work to ensure that more mental health clinicians and Emergency Department staff are approved as MHOs.

13. Approved Facilities and Personnel

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

13.1 Approved Facilities

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

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

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

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

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

Approved Hospitals and Assessment Centres

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

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

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

There are five approved hospitals in Tasmania:

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

Each approved hospital is also an approved assessment centre.

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

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

On 20 April 2020 the Minister for Mental Health and Wellbeing the Hon Jeremy Rockliff MP approved premises known as the Mersey Community Hospital at Latrobe as an assessment centre for the purposes of the Act. The approval took effect on 20 April 202 and will expire on 15 May 2020 unless sooner revoked. The approval was given in response to the closure of the NWRH on 13 April 2020 due to COVID-19.

Secure Mental Health Units

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

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

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

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

Secure Institutions

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

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

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

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

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

13.2 Approved Personnel

Approved Medical Practitioners

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

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

The Chief Psychiatrists may approve people individually. Alternatively, the Chief Psychiatrists may approve all members of a class of people.

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

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

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

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

Approved Nurses

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

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

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

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

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

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

Mental Health Officers

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

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

As with AMPs and approved nurses, the Chief Psychiatrists may approve people individually. The Chief Psychiatrists may also approve all members of a class of people.

As is the case with AMPs and approved nurses, there are limitations on who can be approved as an MHO, and only people who have skills, qualifications or experience relevant to the responsibilities of MHOs under the relevant provisions of the Act or other Acts, may be approved.

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

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

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

The *Gazette* is available online here: www.gazette.tas.gov.au

Identity Cards

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

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

Authorised Persons

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

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

13.2.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question in respect of approved facilities and personnel, as follows:

- Question 21: Are provisions for the approval and authorisation of facilities and people operating effectively and efficiently?

Five respondents commented on matters relating to the approval of facilities and people under the Act.

The Southern FLAG commented on the approval of facilities and suggested that the Act should consider personnel in Emergency Departments when approval is being determined. The Southern FLAG noted that some consumers, families and carers have reported the Emergency Department to be a traumatic place to receive treatment with potential to cause further harm and that taking consumers to the Emergency Department as a first port of call is contrary to the Act's "preference for community support and early intervention".

One respondent commented on the capacity for medical practitioners based in Emergency Departments to be AMPs and suggested that enabling medical practitioners based in Emergency Departments to be AMPs would enable patients to be detained and treated more safely.

Tasmania Police also noted issues that have been experienced when there has not been an MHO to hand over custody of people to at approved hospitals and asked that this be addressed.

Several respondents commented on the need for more and better training for approved personnel. One respondent commented specifically on the need to look to other countries that do this well, including the United Kingdom and New Zealand. Another respondent suggested the need to ensure input from Clinical Nurse Educators to training devised for approved nurses and MHOs in particular.

Review Outcome 20:

Provisions for the approval and authorisation of facilities and people are operating effectively and efficiently.

Issues exist with the nature of facilities that are approved, the number of people that are approved and the education and training available and provided to people who are approved or who are seeking approval.

13.2.2 Government Response

The Government notes feedback received on the extent to which provisions for the approval and authorisation of facilities and people contained in the Act are operating effectively and efficiently.

Government Response to Review Outcome 20:

Education and Training Response

The Government will develop and deliver education and training for MHOs, AMPs, approved nurses and others in their responsibilities and obligations under the Act. Education and training that is developed and delivered will clarify the obligation for MHOs who are based in Emergency Departments to comply with requests from police officers and other MHOs to accept the protective custody of a person where that custody is handed over, in relevant circumstances.

Resource-Related Response

The Tasmanian Health Service will work to ensure that more Emergency Department staff are approved as either medical practitioners or MHOs, as relevant.

14. Information Management

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

14.1 Notifications

Admissions, Transfers and Discharges

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

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

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

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

Leave and Unlawful Absences

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

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

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

14.2 Withholding Information

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

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

14.3 Prohibition on Publication

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

14.4 Disclosure of Confidential or Personal Information

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

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

14.5 Record Keeping

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

Records Generally

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

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

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

Monthly Reports on Voluntary Inpatients

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

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

Forensic Patient Records

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

The controlling authority is also required to provide a copy of records kept to the MHT and the CFP on a weekly basis.

The MHT and/or CFP have review and oversight functions in relation to these matters and provision of the report as required by section 114 facilitates this.

14.6 Information for Parents

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

14.6.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question about information management and record keeping, as follows:

- Question 22: Are provisions of the Act for information management and record keeping operating effectively and efficiently?

Five respondents provided feedback in response to this question.

The Tasmanian Department of Education expressed an interest in enhancing collaboration and information sharing across Agencies when there are students with complex mental health needs that are impacting on their capacity to access and participate in education. The Department of Education suggested that this is particularly relevant in the context of young people who have presented to Emergency Departments due to heightened risk of suicide, but where schools are not made aware of the incident and associated risks to ensure adequate support is provided once the young person returns to school. The Department suggested that improvement to information sharing in these contexts could assist in supporting young people experiencing mental health issues.

One respondent queried why provisions of the Act for information management appear to apply to involuntary patients only and suggested they are equally pertinent to all patients.

The Southern FLAG provided feedback suggesting that patients should be given the opportunity to have all information provided to them in their preferred language and that this is not happening despite the technology available to do so.

The Southern FLAG also suggested that:

- "malpractice" is often not recorded at all
- consumer records do not accurately reflect professional diagnosis, and
- treatment plans "don't seem to be happening".

Commenting on section 114 of the Act, the MHT noted the controlling authority's obligation to provide the MHT with weekly records relating to the operation of the secure mental health unit and suggested that there may be merit in providing these also to Official Visitors so that potential issues can be identified and raised with patients when visiting the Wilfred Lopes Centre.

Commenting on section 134 of the Act specifically, the Department of Communities Tasmania suggested the need to include the National Disability Insurance Scheme Quality and Safeguards Commission and the National Disability Insurance Agency as bodies with whom information may be shared to facilitate lawful provision of information necessary for planning, quality and safeguarding and complaints investigation processes undertaken by those bodies.

Review Outcome 21:

Provisions of the Act for information management and record keeping are generally operating effectively and efficiently but could be improved if they were extended to voluntary patients, were applied with reference to available technologies to improve the provision of information to patients, and if they facilitated greater information sharing in relevant circumstances.

14.6.2 Government Response

The Government notes feedback received on the extent to which provisions of the Act for information management and record keeping are operating effectively and efficiently.

Government Response to Review Outcome 21:

Legislative Response

The Government will amend section 114 of the Act to include the Principal Official Visitor as a body to whom the controlling authority is to give records.

The Government will consider amending section 134 of the Act to enable information to be disclosed to the Department of Education with respect to students with complex mental health needs, and to the National Disability Insurance Scheme Quality and Safeguards Commission and National Disability Insurance Agency in relevant circumstances.

The Government will also consider amending section 134 of the Act to extend its application to information of a confidential or personal nature that is obtained about a voluntary patient.

Education and Training Response

The Government will develop and deliver education and training to clinicians and others to reinforce the requirement for patients and others to be given information in a language and form that the person can understand.

The Government will deliver education to consumers, families, friends and carers to ensure they are aware of the complaints process and the avenues available to them to resolve complaints and allegations.

Documentation and Processes Response

In reviewing existing documentation and developing new documentation associated with the Act, the Government will consider new ways of communicating including the use of visual information such as pictures or video messages, available technologies such as iPads, and increased use of peer workers.

The Government will also consider the need for key documentation including Statement of Rights to be translated into languages other than English.

15. Mental Health Tribunal

15.1 Tribunal Establishment, Powers and Functions

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

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

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

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

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

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

15.2 Establishment

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

- at least one member who is an Australian lawyer with at least five years' standing as an Australian legal practitioner
- at least one member who is a psychiatrist, and
- at least four other members.

Each of the members is appointed by the Governor.

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

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

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

Schedule 3 also:

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

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

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

At the time this document was prepared, there were 39 additional appointed members.

Registrar and Staff

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

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

Independence

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

Reporting

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

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

15.3 Functions and Powers

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

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

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

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

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

- combine a mandatory review with a discretionary review
- refer any matter concerning a review to the relevant Chief Psychiatrist for possible direct intervention
- issue related or incidental directions when making a determination
- require a person to appear before it to give evidence or produce documents and to answer questions
- require a patient in proceedings to be examined with respect to the patient's physical, psychological and mental capacities by a medical practitioner

- require reports from a Chief Psychiatrist or the controlling authority of an approved facility, and
- visit and interview a patient by or in respect of whom an application has been made, in private.

Powers of the President

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

The President may also:

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

MHT Guidelines

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

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

One MHT Guideline have been issued.

Approved Forms

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

- Application for Treatment Order (adult and child), Application for Variation of Treatment Orders, Application for Leave of Absence, Application for Renewal of Treatment Order
- documentation evidencing a Treatment Order's discharge (Discharge Paper)
- Application of Authorisation of Treatment for a Forensic Patient
- interim authorisation of treatment for a forensic patient, and any revocation or variation of this
- monthly reports on the accommodation and treatment of long-term voluntary inpatients, and
- applications to the MHT for reviews and other matters.

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

Each of the MHT's forms can be completed electronically.

Practice Directions

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

The MHT has issued 30 practice directions to date.

15.3.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question about provisions of the Act for the Tribunal's establishment, powers and functions, as follows:

- Question 23: Are provisions of the Act for the establishment, powers and functions of the MHT operating effectively and efficiently?

The LACT and MHT provided feedback on the MHT's establishment, powers and functions.

The LACT expressed the view that the establishment of specialist multidisciplinary Tribunal panels (comprising a psychiatrist, lawyer and community member) as the independent arbiters authorising involuntary treatment is an advantage and positive aspect of the Act.

The MHT commented on its review functions under the Act, noting that the vast majority of reviews (other than mandatory reviews of Treatment Orders conducted under section 181 of the Act) conducted since the Act's commencement have been "own motion" reviews. Only a small number of patients have sought reviews of Treatment Orders and these have generally been refused on the basis that the MHT has concluded a review of the same matter within the preceding three months, or because there is nothing in the application to indicate that there has been any material change in the relevant circumstances since the previous review.

The MHT also noted that some reviews conducted under the Act may be ineffective because they occur too late to have any impact on the matter which is the subject of the review. The MHT gave the example of urgent circumstances treatment, which may be administered before the MHT has an opportunity to set or hear the matter. The MHT suggested either amending the Act or making greater use of the Official Visitor oversight functions to assess and conduct preliminary inquiries into complaints received from, or concerning, patients and acting as a conduit between the patient and the Tribunal. The MHT noted that the operation of Official Visitors is constrained by funding and they may not be able to undertake such a role presently.

Several respondents provided feedback on the forms required to be used under the Act. In terms of forms that have been approved by the MHT, one respondent noted that while the Application for renewal of Treatment Order form is easily edited because it is a Microsoft Word document, the formatting of the document itself is difficult to work with. Staff from the Tasmanian Health Service also expressed support for the capacity to complete forms online as a way of minimising inadvertent mistakes.

Review Outcome 22:

Provisions of the Act for the establishment, powers and functions of the MHT are operating effectively and efficiently.

At least some respondents have some issues with forms required to be used under the Act, including forms that have been approved by the President of the MHT for use under the Act.

15.4 Tribunal Proceedings

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

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

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

General Procedures

Under Schedule 4 of the Act, the MHT:

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

Evidence, Representation and Privacy

Schedule 4 of the Act provides as follows:

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

Publication of Proceedings, Announcement of Decisions and Statements of Reasons

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

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

The MHT may announce its determination at the end of proceedings. The way this is to occur are set out in Schedule 4.

Any party to proceedings may apply to the MHT within 30 days of proceedings being finally determined for a written statement of reasons for making a determination. The MHT is to comply with such a request within 21 days of receiving it, and any statement of reasons that is produced is to be provided to every party to the proceedings.

Divisions and Acting by Majority

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

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

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

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

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

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

Determinations

Evidence of Tribunal Determinations

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

Interim Determinations on Adjournment

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

Questions of Law and Appeals

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

The circumstances in which an appeal may be made in respect of an MHT determination, and the procedure for this are set out in sections 173 and 174 of the Act respectively.

Refusal of Reviews, On-Paper Reviews and Preliminary Evaluation

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

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

The circumstances in which the Registrar may conduct an on-paper review are narrow. In particular, the Registrar may only conduct reviews on the papers if authorised to do so by the President of the Tribunal; and the President may only authorise the Registrar to conduct a review on the papers if satisfied that no hearing is required, and that it is within the Registrar's competence to do such a review. The ability for the

Registrar to conduct a review on the papers additionally does not extend to a 60-day or 180-day review of a Treatment Order, or a 60-day or 180-day review of the authorisation of treatment for a forensic patient.

Contempt

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

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

15.5 Other Developments

The Department of Justice released a Discussion Paper proposing establishment of a Single Tribunal for Tasmania in September 2015. The Department of Justice is understood to continue to be moving towards achievement of a Single Tribunal which will see the MHT amalgamated as part of the Single Tribunal's establishment.

15.5.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question about the Tribunal's proceedings, as follows:

- Question 24: Are provisions of the Act for the MHT's proceedings and determinations operating effectively and efficiently?

Seven respondents commented on this question.

Carers Tasmania conveyed feedback suggesting that MHT proceedings are generally satisfactory while RANZCP Tasmanian Branch noted that the feeling of the consultant psychiatrists who sit on the MHT is that provisions of the Act for the MHT's proceedings and determinations are operating effectively.

Several respondents commented on the Tribunal's role with respect to clinical judgements, with comments received suggesting a potential lack of clarity with respect to the MHT's role as a decision-making and oversight body.

Several respondents also commented on the formal nature and frequency of the MHT's proceedings suggesting that these can sometimes be confronting to staff, consumers and carers. Carers Tasmania suggested that the provision of information sessions and support for carers through these processes would be helpful. Staff from the Tasmanian Health Service suggested that patients report being "retraumatised" by having to sit in multiple hearings and hearing information including information that they are trying to put behind them presented repeatedly and queried whether information on patient history that has already been presented for the current Order could be taken "as read" from records of previous hearings at review as a way to addressing this concern.

Some respondents including the Southern FLAG provided comments suggesting that some consumers do not feel that they are "heard" in Tribunal proceedings.

The RANZCP Tasmanian Branch noted that issues of service delivery, unavailability of staff to attend hearings and incomplete and late paperwork have a negative impact on the MHT's workload and deliberations.

In terms of resourcing, the Southern FLAG commented on the MHT's operating hours (Monday to Friday, 8.45 am to 5.00 pm) suggesting that these are less than ideal. The MHT also commented on the resourcing

required to support the Act and suggested that the financial impact of the Act was underestimated when it was first introduced to Parliament.

The LACT commented that less than a quarter of patients who attend civil hearings have representation and that only 13 per cent were represented by a lawyer with the other ten per cent being supported at hearings by mental health representatives from Advocacy Tasmania who support clients to put their wishes to the MHT. The small proportion of patients who are represented at civil hearings was also noted by the MHT, which suggested a significant shortfall in resources for representation of patients whether by a lawyer or advocate.

The LACT noted lack of access to the patient's clinical file prior to a hearing which the LACT noted impacts their ability to advise and represent their clients and causes hearings to be adjourned or delayed. This has an administrative and economic cost and can increase the time that a person is involuntarily detained.

A Tasmanian Health Service staff member noted that the requirement for all forms sent to the MHT to be completed solely by AMPs potentially restricts the opinion provided to the MHT to medical opinion. This is difficult in a multidisciplinary team model and potentially identifies the doctor as a persecutor. The respondent's comments suggested that a better approach may be to ask all team members for submissions.

Carers Tasmania conveyed anecdotal feedback received from carers over the years which suggests that carers have not received information regarding hearings until it is sometimes too late to attend at all, and often too late to prepare and participate in a planned manner.

The LACT commented on the time available for hearings and statements of reasons. In the LACT's view the time provided for hearings is short and may be insufficient to adequately present a client's case. In the LACT's observation, oral statements of reasons are not always provided which in the LACT's view makes it difficult to explain to clients why the Order has been made or to advise them about their options including appeal rights. While the Act enables a request to be made for a written statement of the MHT's reasons for making any determination it does not specify what the reasons should contain, and in the LACT's view statements of reasons do not always make findings of fact or law. The LACT stated that this makes it even harder to explain why the Order has been made and what the consumer's rights of appeal are.

The President of the MHT provided an alternative view, suggesting that the Act requires the MHT to provide oral reasons at hearings, and they do, except, for example, where a patient may be floridly psychotic and it is not in their best interests to go into great detail at the actual hearing.

Review Outcome 23:

At least for some people, provisions of the Act for the MHT's proceedings and determinations are not operating effectively and efficiently. For those people, there is a view that some aspects of the Tribunal's practices and approaches could be reviewed.

15.5.2 Government Response

The Government notes feedback received on the extent to which provisions of the Act for the MHT's establishment, powers and functions, and for the MHT's proceedings and determinations are operating effectively and efficiently.

Government Response to Review Outcomes 22 and 23:

Legislative Response

The Government will consider amending the Act to address feedback provided by the MHT which suggests that many reviews may be ineffective because they occur at a point when the outcome of the review can have little impact on the matter the subject of the review.

The Government will, following further consultation with the MHT and Principal Official Visitor, consider amending the Act to enable the Tribunal to refer matters that are raised with it to the Principal Official Visitor, and to enable the Principal Official Visitor to conduct a preliminary inquiry.

The Government will consider amending the Act to alter the circumstances in which the MHT may refuse to review a matter that it has been asked to review by a patient or other person, to reduce the number of reviews that are sought but refused because the MHT has concluded a review of the same matter within the preceding three (3) months, or because there is nothing in the application to indicate that there has been any material change in the relevant circumstances since the previous review.

Education and Training Response

The MHT will review existing documentation to ensure that it clearly and accurately describes the MHT's functions and mode of operation including how to ask the MHT for a review and how to access advocacy and legal representation.

The Chief Psychiatrists and MHT will work together to develop and deliver education and training for clinicians and others about the role of the psychiatrist member of the MHT, and on the MHT's role as a decision-making and oversight body.

Lastly the MHT will review existing education and training for MHT members to assist them to ensure that hearings are conducted in a manner that is less confronting to and inclusive of staff, consumers and carers.

Documentation and Processes Response

The MHT will review relevant MHT-approved forms to make them more consistent in format.

The Government will explore options to enable all MHT-approved forms to be completed online.

The MHT will review its processes to identify how proceedings can be made less confronting to staff, consumers and carers and to reduce the need for patients to "tell their story" more than once.

The Tasmanian Health Service will review their processes to facilitate access by advocates and legal representatives to patient files before hearings.

The MHT and Tasmanian Health Service will work together to facilitate greater involvement of members of the patient's treating team other than the patient's treating medical practitioner in Tribunal hearing processes.

The MHT will identify ways to ensure that carers and others are provided with notice of hearings as far in advance of the hearing as possible.

Lastly, the MHT will work with the Tasmanian Health Service to explore how patients who are acutely unwell can best be provided with an understanding of the reasons for decisions immediately after hearings.

Resource-Related Response

The Government will consider any funding submissions in relation to this Review Outcome, through future Budget processes.

16. Official Visitors

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

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

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

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

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

More information about Mental Health Official Visitors in Tasmania can be found here: www.officialvisitors.tas.gov.au/mental-health-official-visitors

16.1 The Principal Official Visitor

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

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

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

Functions and Powers

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

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

- determining how Official Visitors are to perform their functions.

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

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

Independence

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

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

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

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

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

Reporting

The Principal Official Visitor has the following reporting obligations:

- If the Principal Official Visitor knows or reasonably suspects that the Act has been contravened in any material way, he or she is to report the matter to the Health Complaints Commissioner or Ombudsman, whichever body seems appropriate in the circumstances.
- The Principal Official Visitor is required to give the Minister for Health, and relevant Chief Psychiatrist, a written report on a quarterly basis. A copy is also to be provided to the controlling authority of the facility that the person is in or to the person in charge of the premises from which relevant services are provided, as relevant.
- The Principal Official Visitor is also required to give the Minister for Health, and relevant Chief Psychiatrist, a report on matters of concern if requested by the Minister. A copy is also to be provided to the controlling authority of the facility that the person is in or to the person in charge of the premises from which relevant services are provided, as relevant.

Identification

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

16.2 Official Visitors

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

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

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

Functions and Powers

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

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

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

Independence

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

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

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

16.3 Visits

Visits are regulated under section 160 of the Act.

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

The Principal Official Visitor is also required to arrange for an Official Visitor to visit premises in, or from which, a voluntary inpatient, involuntary patient or forensic patient is being provided with services under the Act but only if asked to do so by:

- the patient
- a representative or support person of the patient
- a person who the Principal Official Visitor believes has a genuine interest in the patient's welfare, or
- the relevant Minister.

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

Visits may be made with or without notice.

16.4 Complaints

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

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

Obligation to Assist

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

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

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

16.4.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question with respect to the Principal Official Visitor and Official Visitors, as follows:

- Question 25: Are provisions of the Act for the appointment, powers and functions and other matters associated with Official Visitors operating effectively and efficiently?

Five respondents commented specifically in respect of this question.

The Manager of the Mental Health Official Visitors scheme provided feedback on specific aspects of the provisions of the Act that apply to Official Visitors, including as follows:

- While section 156 of the Act allows the Principal Official Visitor to raise matters of concern with the Minister or relevant Chief Psychiatrist, in practical terms the controlling authority has day to day

responsibility for the management of mental health facilities and is better placed to address matters of concern that come to the Principal Official Visitor's attention. The Manager raised similar issues with respect to subsection 165(2) of the Act, which allows the Principal Official Visitor to make a private report to the Minister or relevant Chief Psychiatrist.

- Under section 157 of the Act Official Visitors can receive complaints, refer complaints to the Principal Official Visitor and report suspected contraventions of the Act or matters requiring investigation to the Principal Official Visitor. The Act does not however provide any mechanism for an Official Visitor to determine if there has been a contravention of the Act before a matter is referred or reported for investigation.
- Subsection 163(3) requires a person discharging responsibilities under the Act to take certain actions including granting Official Visitors access to records and requiring a person to answer questions but ostensibly only insofar as they relate to a patient who has expressed a wish to see or complain to an Official Visitor. This means that an Official Visitor cannot examine any records or registers kept under the Act concerning, for example, patients who are in seclusion and unable to make a complaint.

The Manager also provided feedback suggesting that it is not clear how an Official Visitor should treat a complaint made by a child patient under section 157 of the Act in circumstances where the child is being treated with parental consent or is subject to the provisions of the *Children, Young Persons and their Families Act*. This feedback was echoed by the Commissioner for Children in the Commissioner's submission to the review.

Two other respondents commented on the scope of Official Visitors powers and expressed concern about the capacity for Official Visitors to investigate matters relating to patients who are secluded or restrained with consent from a guardian or parent (that is, who are voluntary patients).

Carers Tasmania reported limited knowledge of the role of Official Visitors in consultations conducted for the review and suggested that given this there may need to be further promotion of the program and how families and friends caring for someone can engage, as well as how the program may be beneficial to patients.

The Southern FLAG noted that consumers are often unaware that they can access Official Visitors, which makes it difficult for an unsupported consumer to make contact. The Group also commented on the number of Official Visitors and suggested that having only ten Official Visitors constrains the ability for Official Visitors to protect consumers who are in approved facilities but who do not fall under the Act.

Review Outcome 24:

Provisions of the Act for the appointment, powers and functions and other matters associated with Official Visitors are operating effectively and efficiently but may be able to be improved with some minor changes to the Act's provisions to clarify the powers and functions of Official Visitors with respect to people who have not expressed a wish to see or complain to an Official Visitor, and children, through greater education and training of consumers and carers around the role and function of Official Visitors, and through increased resourcing.

16.4.2 Government Response

The Government notes feedback received on the operation of the Act's provisions as they concern Official Visitors.

Government Response to Review Outcome 24:

Legislative Response

The Government will consider whether section 156 of the Act to enable the Principal Official Visitor to raise matters of part concern that come to the Principal Official Visitor's attention with the controlling authority of an approved facility as well as with the responsible Minister or relevant Chief Psychiatrist.

The Government will also consider amending section 165 of the Act to expand the people to whom the Principal Official Visitor may give a private report to include the controlling authority of an approved facility.

The Government will consider amendments to clarify if, and if so how, an Official Visitor should manage complaints that are made by child patients and other voluntary patients.

The Government will also consider amendments to clarify how Official Visitors are to determine whether there has been a contravention of the Act. As part of this process the Government will consider amendments to section 163 of the Act to extend the obligations set out in it to all people discharging responsibilities under the Act (not just to those people who know that a patient has expressed a wish to see or complain to an Official Visitor), and to enable the Principal Official Visitor to conduct a preliminary inquiry that is referred by the MHT.

Education and Training Response

The Government will develop and deliver education and training to assist carers and consumers to better understand in the role and function of the Principal Official Visitor and Official Visitors.

Documentation and Processes Response

The Government will review Statements of Rights and other documentation to ensure that it clearly identifies how to contact Official Visitors.

Resource-Related Response

The Government will consider any funding submissions in relation to this Review Outcome, through future Budget processes.

17. Chief Civil Psychiatrist and Chief Forensic Psychiatrist

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

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

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

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

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

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

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

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

The legislation in place in other States and Territories provides for the concept of Chief Psychiatrists and the inclusion of the Chief Psychiatrist role in legislation 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 (these are now the Tasmanian Health Service).

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

17.1 Responsibilities

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

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

Independence

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

Reporting

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

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

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

17.2 Powers and Functions

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

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

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

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

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

Approved Forms

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

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

A full listing of the forms that have been approved is also provided at Appendix M.

Of the forms approved by the Chief Psychiatrists, only Chief Civil Psychiatrist Approved Form 7 can be completed electronically.

Standing Orders

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

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

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

- Urgent Circumstances Treatment (Involuntary Patients) (CCP Standing Order 8).
- Seclusion (Involuntary Patients) (CCP Standing Order 9).
- Chemical Restraint (Involuntary Patients) (CCP Standing Order 10).
- Mechanical Restraint and Physical Restraint (Involuntary Patients) (CCP Standing Order 10A).

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

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

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

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

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

Clinical Guidelines

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

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

The CCP has issued Clinical Guidelines in respect of the following matters:

- The meaning of mental illness (CCP Clinical Guideline 1).
- The off-label use of medications (CCP Clinical Guideline 7).
- Urgent Circumstances Treatment (Involuntary Patients) (CCP Clinical Guideline 8).
- Seclusion (Involuntary Patients) (CCP Clinical Guideline 9).
- Chemical Restraint (Involuntary Patients) (CCP Clinical Guideline 10).
- Mechanical Restraint and Physical Restraint (Involuntary Patients) (CCP Clinical Guideline10A).

The CFP has issued Clinical Guidelines in respect of the following matters:

- Urgent Circumstances Treatment (Forensic Patients) (CFP Clinical Guideline 8).
- Seclusion (Forensic Patients) (CFP Clinical Guideline 9).
- Chemical Restraint (Forensic Patients) (CFP Clinical Guideline 10).
- Mechanical Restraint and Physical Restraint (Forensic Patients) (CFP Clinical Guideline 10A).

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

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

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

Power of Direct Intervention

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

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

- The power of direct intervention may only be exercised with respect to voluntary inpatients, involuntary patients or forensic patients.
- The power of direct intervention may be exercised on the Chief Psychiatrist's own motion, or on request of the patient or any other person who, in the Chief Psychiatrist's opinion, has a genuine interest in the patient's health, safety or welfare.
- The power of direct intervention may only be exercised if the Chief Psychiatrist has made inquiries into the matter and is satisfied from those inquiries that intervention is essential to the patient's health, safety or welfare.
- The power of direct intervention may only be exercised in respect of the following matters:
    - the use of seclusion, restraint or force
    - the granting, refusal and control of leaves of absence
    - the giving or withholding of patient information
    - the granting, denial and control of visiting, correspondence and telephone rights
    - assessment and treatment generally, and
    - matters prescribed by the regulations.

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

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

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

Delegation

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

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

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

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

The Chief Psychiatrists can delegate their functions or powers to:

- a person by name, or
- the holder of a State Service office or position, by reference to the title of the office or position concerned.

This is by virtue of section 23AA of the *Acts Interpretation Act 1931* (Tas), which applies to the Chief Psychiatrists' power to delegate.

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

17.2.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question with respect to the Chief Civil Psychiatrist and Chief Forensic Psychiatrist, as follows:

- Question 26: Are provisions of the Act for the appointment, powers and functions and other matters associated with the Chief Psychiatrists operating effectively and efficiently.

None of the submission received commented specifically on the appointment, responsibilities, powers or functions of the Chief Psychiatrists.

Six submissions commented on matters relating to forms required to be used under the Act, including forms that have been approved by the Chief Psychiatrists. Feedback received suggested that the forms required to be used under the Act, including forms that have been approved by the Chief Psychiatrists are difficult to use, time consuming, repetitive and stressful to complete, hard to find and overly complex.

This sentiment was, to some degree, also expressed by the RANZCP Tasmanian Branch which stated that:

> *"While not a matter requiring any change to the legislation, the feeling of many Fellows of the Branch, and the Tribunal psychiatrists and Registrars is that the work of the Tribunal is hampered by the current documentation and paperwork that has been set up. The number of forms and repetitive tasks have created confusion not only amongst mental health clinicians but also amongst Emergency Department practitioners. The evidentiary value of the forms for the Tribunal's proceedings is very limited".*

Staff from the Tasmanian Health Service expressed support for the ability to complete forms online as a way of minimising inadvertent mistakes.

In terms of forms that have been approved by the Chief Psychiatrists:

- The MHT observed that in a significant number of instances, protective custody paperwork is not completed despite evidence in other documentation that the patient was brought in by police.
- Staff of the Tasmanian Health Service provided feedback suggesting confusion about whether it is necessary to complete forms for decision-making capacity and urgent circumstances treatment at the time that an Assessment Order is made.
- One staff member from the Tasmanian Health Service suggested the need for consistency in the format used across forms that have been approved by the Chief Psychiatrists. The staff member also suggested including a "strengths" section in the treatment plan as a way of counterbalancing a frequently heard complaint from patients that Act processes and hearings focus on negatives. The staff member suggested that this would also be consistent with a patient-centred, recovery and rehabilitation framework.

Review Outcome 25:

Provisions for the appointment, powers and functions and other matters associated with the Chief Psychiatrists are operating effectively and efficiently.

There are issues with the forms approved by the Chief Psychiatrists for use under the Act including that they are difficult to use, time consuming, repetitive and stressful to complete, hard to find and overly complex, and cannot be completed online.

17.2.2 Government Response

The Government notes feedback received on the operation of provisions for matters associated with the Chief Psychiatrists.

Government Response to Review Outcome 25:

Education and Training Response

The Government will develop and deliver education and training to statutory officers and others in how to complete forms that have been approved by the Chief Psychiatrists.

Documentation and Processes Response

The Chief Psychiatrists will review all Chief Psychiatrist approved forms to make them easier to access, easier and quicker to complete, less repetitive, simpler and more consistent in format.

The Government will explore options to enable all Chief Psychiatrist approved forms to be completed online.

18. Interstate Arrangements

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

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

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

18.1 Interstate Transfer Agreements

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

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

18.2 Interstate Control Agreements

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

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

18.3 Tasmanian Context

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

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

18.4 Other Developments

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

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

The potential for such changes requires jurisdictions to be proactive in ensuring the ongoing validity of interstate agreements.

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

Action 26 of the Fifth Plan requires Governments to improve consistency across jurisdictions in mental health legislation with a view to ensuring seamless and safe care for consumers, particularly consumers who move between states and territories. Queensland and Tasmania are project leads for Action 26 of the Fifth Plan and jointly developed a paper proposing 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.

18.4.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document noted that provisions of the Act for interstate agreements are not operational and that it is not possible to make any changes to the provisions until such time as there is a shared commitment across jurisdictions to pursuing a national legislative scheme before commenting that feedback on any aspect of the sections is nevertheless welcomed.

Two respondents commented on this issue, as follows:

- Carers Tasmania noted the lack of a national legislative scheme and expressed the view that this challenges family and friends caring for someone who moves from state to state while unwell.
- Fellows of the RANZCP Tasmanian Branch expressed strong support for review of state and territory legislation so that patients can be transferred between jurisdictions under involuntary orders to ensure appropriate management and effective intervention. The Branch also suggested the need to ensure some uniformity in the definition of mental illness between the various State of Australia which would facilitate in part the making of effective interstate provisions.

In January 2020 the Council of Australian Governments Health Council agreed to the progression of a project that will develop a nationally consistent approach to the recognition of mental health orders in each state. Funding has been made available to Queensland as the jurisdiction that will lead this project.

No outcome applies to this aspect of the Consultation Document.

19. Other Matters

19.1 Rights and Responsibilities of Carers and Family Members

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

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

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

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

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

As has already been noted, parents of children with mental illness also have:

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

More detail on the rights and responsibilities of support people and representatives of people with mental illness is provided in the Chief Civil Psychiatrist and Chief Forensic Psychiatrist's Clinical Guideline 3 – Representatives and Support Persons, which can be accessed here: www.dhhs.tas.gov.au/__data/assets/pdf_file/0010/252748/CCP_Clinical_Guideline_3_-_Rep_and_Support_Persons_.pdf

19.1.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question on the rights and responsibilities of carers and family members under the Act:

- Question 28: Is the Act operating as intended to maximise and promote consumer involvement in decision-making while facilitating the involvement of carers and family members to the extent that this is consistent with the consumer's wishes? If not, why do you think this is?

Four respondents provided specific feedback in response to this question.

One respondent expressed the view that the Act is not operating as intended to maximise and promote consumer involvement in decision-making while facilitating the involvement of carers and family members. The respondent cited carers not being advised of restraint and seclusion events in support of this view.

Carers Tasmania provided significant feedback, collected from carers and family members, in response to this question. Feedback received by Carers Tasmania suggested that the Act is mostly sound, but that the lack of resources and other factors make it difficult to implement the Act as it is intended. For example:

- The Mental Health Service Delivery Principles acknowledge a significant intention to engage with carers however feedback from carers suggests that often they aren't heard or are treated unfavourably as a result of their efforts to advocate for themselves and the person they care for.
- Carers express concern that they hold valuable information about the person but are not included in the treatment of the person they care for, and this exclusion is unnecessarily (in the carer's view) shrouded behind the patient's right to privacy. Carers Tasmania noted situations where this approach appears to have put carers at risk. For example, not sharing details about a patient's discharge with the carer, when the carer perceived themselves to be at significant risk, as their family member had incorporated them into their delusions and made threats of violence to them prior to admission. While carers told Carers Tasmania they have expressed these fears to clinicians, their feeling is that their fears are not heard unless the patient articulates them directly to the clinician. Carers Tasmania suggested that carers are very clear they do not feel they need to know everything about the treatment of the person they care for but that there are things they need to know, as ultimately, they are supporting and assisting with the engagement and navigation of the mental health system in order to access treatment effectively. The provision of practical information such as appointment times and attendance issues were seen as particularly important and not routinely offered.

Carers Tasmania noted their observation at consultations and more generally that carers do not have a great understanding of the Act and only a limited understanding of other intersecting legislation such as the *Guardianship and Administration Act*. Carers Tasmania also expressed concern about carers and family members who are not connected to Carers Tasmania and Mental Health Family and Friends Tasmania and

their ability to access practical advice and information. Carers Tasmania suggested that information needs to be routinely provided, and provided at various touchpoints, when the carer has capacity to absorb and respond to the information they receive, and that carers may need basic training in navigating the mental health system and ensuring they are skilled in advocacy and navigating the more formal components of the system. Carers Tasmania suggested some brief YouTube videos could be developed to cover key components of the Act. Carers Tasmania also suggested utilising the MHT and Official Visitors to deliver information sessions to carers regarding how they work and how carers can be involved.

In response to this feedback, Carers Tasmania suggested the need for the culture of Mental Health Services to shift and involve carer inclusion as standard practice. Carers Tasmania pointed to the MHHITH service as an example where training regarding engaging with carers has been provided, and peer workers are part of the culture of the program.

Carers Tasmania also referred to the *Tasmanian Carer Policy 2016* and what Carers Tasmania described as its focus on ensuring that carers are acknowledged and treated as individuals with their own needs within and beyond their caring role, provided with relevant information and referred to appropriate services to assist them in their caring role, respected as valued members of a care team and encouraging the relationship between the carer and the person receiving care to be regarded as a partnership where each person has rights and responsibilities. To this end Carers Tasmania suggested that any changes to the Act should align with any legislation that gives effect to the Policy into the future.

The Southern FLAG also provided commentary relevant to the rights and responsibilities of carers and family members under the Act. The commentary suggested that the concerns of carers are often disregarded, that carers are not asked for advice or kept informed, and that this leads carers to feel invalidated.

Review Outcome 26:

For at least some people, the Act is not operating as intended to maximise and promote consumer involvement in decision-making while facilitating the involvement of carers and family members to the extent that this is consistent with the consumer's wishes.

Reasons for this include lack of resources and the culture and attitude of staff.

19.2 Offences and Immunities

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

Unlawful Treatment

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

Neglect or Ill-Treatment

Section 214 makes it an offence for:

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

Obstruction

Section 215 makes it an offence for a person to obstruct or hinder an AMP, approved nurse, authorised person, Chief Psychiatrist, a member of the MHT, an MHO, the Principal Official Visitor or an Official Visitor, the Registrar or an MHT staff member, the MHT or the controlling authority of an approved facility in discharging any responsibilities under the Act.

Contravention of Tribunal Determinations

Section 216 makes it an offence for a person to contravene a determination or direction of the MHT.

False or Misleading Statements

Section 217 makes it an offence for a person to make a statement knowing it to be false or misleading, or to omit any matter from a statement knowing that without the matter the statement is false or misleading, in giving any information under the Act.

Immunities

Section 218 of the Act provides AMPs, approved nurses, authorised persons, Chief Psychiatrists, members of the MHT, MHOs, the Principal Official Visitor or an Official Visitor, the Registrar or an MHT staff member with the immunities set out in the section.

19.2.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question with respect to offences and immunities:

- Question 29: Are provisions of the Act relating to offences and immunities operating effectively and efficiently?

Three of the submissions received provided specific feedback on the offences and immunities provisions of the Act.

Several respondents commented on section 218 of the Act, suggesting that it is perceived to provide blanket immunity to clinicians and others. The Southern FLAG went so far as to say that the section is considered by consumers to be one of the biggest flaws when it comes to consumer rights and practitioner responsibilities under the Act and suggested that there needs to be some limit or test applied to the clause.

The Southern FLAG suggested consideration be given to the support needs of consumers who believe that they have been the "victims of malpractice" and that the LACT, or another organisation, could be given a role in helping consumers in this regard.

Review Outcome 27:

Provisions of the Act relating to offences and immunities are operating effectively and efficiently except with respect to section 218 of the Act, which is viewed as preventing accountability and transparency with respect to actions of staff and clinicians under the Act.

19.3 Remote Medical Procedures, Powers of Sedation, Conflicts of Interest and Correction of Orders

Remote Medical Procedures

Section 211 confirms that assessments, examinations, diagnosis and treatment and other medical procedures may be carried out in person or by video conferencing or use of other technical means allowed by the operating protocols of the facility from or in which the procedure is carried out, Clinical Guidelines or Standing Orders.

Powers of Sedation

An ambulance officer or medical practitioner who is approved as an MHO under the Act may sedate a patient who is being transported by ambulance in the circumstances set out in section 212 of the Act.

Conflicts of Interest

Section 222 regulates conflicts of interest and identifies when a person has a clear conflict of interest and prevents a person with a clear conflict of interests from discharging responsibilities in respect of patients under the Act.

Correction of Orders

The circumstances in which an error in a form that does not affect the validity of an Order, determination, direction or other document under the Act may be corrected are set out in section 224 of the Act.

The circumstances in which an error in an Order, determination, direction or other document made by the MHT under the Act that affects the validity of the Order, determination, direction or other document may be corrected are set out in section 224A of the Act.

19.3.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question:

- Question 30: Are provisions of the Act relating to remote medical procedures, powers of sedation, conflicts of interest and the correction of orders operating effectively and efficiently?

None of the submissions received provided specific feedback in respect of remote medical procedures, powers or sedation or conflicts of interest.

Staff of the Tasmanian Health Service provided feedback in respect of correction of orders, suggesting that the Act should allow for 14 days to fix documentation issues with forms.

The MHT queried section 223 (providing for defects in appointments etc) and whether the section would operate to validate an Assessment Order or Treatment Order that does not meet the requirements of the Act.

Review Outcome 28:

Provisions of the Act relating to remote medical procedures, powers of sedation, conflicts of interest and the correction of orders are operating effectively and efficiently for most people.

19.4 Any Other Aspects of the Act's Operation

For completeness, the Consultation Document invited feedback on any aspects of the Act's operation not already covered in other components of the Consultation Document.

19.4.1 Consultation Questions, Feedback Received and Review Outcome

The Consultation Document asked one question to elicit feedback of this kind:

- Question 31: Are there any other aspects of the Act's operation that you would like to comment on?

Several respondents provided feedback on aspects of the Act's operation not covered in other parts of the Consultation Document. Feedback received is outlined below.

The Act's Drafting

Several respondents provided feedback on aspects of the Act's drafting, including as follows:

- Several respondents expressed the view that the Act is confusing. For example, one respondent noted that it is difficult to find where things are in the legislation and the Public Guardian (via the Mental Health Act Review Statutory Reference Group) commented that in her view, the Act is difficult to navigate and more visually complex than the *Mental Health Act 1996*, and requires a user to "jump around the Act to really understand it". The MHT also commented on the Act's prescriptive and complicated nature, and its length.
- The Southern FLAG commented that the information in the Act is so complex and "legalistic" that communication of meanings between clinicians, consumers, relatives, community members and legal services is very poor. In the Southern FLAG's view, this leads to practical problems and interpretation problems for consumers and members of the public.
- One respondent suggested that references in the legislation, and in the Standing Orders and Clinical Guidelines, to "the safety of others" and protocols for dealing with violent patients, including all forms of restraint and seclusion, leads an uninformed public, and occasionally staff, into believing that people with mental illness are unpredictable and violent when the evidence does not support this.
- Staff of the Tasmanian Health Service suggested that the issue of risk could be better described under the Act and noted the use of words like "serious harm" or "imminent" in the legislation of other jurisdictions in support of this view.

The Southern FLAG commented on what they view as a lack of cohesion between the Act, other legislation and human rights instruments which, in their view, leads to confusion and problems of implementation. The Southern FLAG suggested that consumers would like legislative developments to reflect the values described in review documents for mental health legislation in the ACT and Victoria, which focus on consumer centred practices that are designed to empower and support all consumers to be involved in their treatment and care rather than on consumers who lack capacity, involuntary admissions and the need to consumers to comply with treatment: "we believe that moving away from this mentality will improve our sense of dignity, mental health outcomes and ongoing welfare".

The MHT commented on the need to review the Act's interaction with other Acts including the *Sentencing Act* and the *Criminal Justice (Mental Impairment) Act.* The MHT provided several examples to support this view including the situation of Treatment Orders made under the *Criminal Justice (Mental Impairment) Act* which are not required to have the same form and content as Treatment Orders made under the Act. The MHT also commented on practical issues associated with the enforcement of Treatment Orders made under the *Criminal Justice (Mental Impairment) Act*, such as communicating the fact that an Order has been made under the *Criminal Justice (Mental Impairment) Act* to the treating team and the MHT.

In terms of the Act's intersection with the *Guardianship and Administration Act* the Mental Health Act Review Statutory Reference Group noted that this intersection will be ongoing while the Act's focus is on treatment for mental illness. For a few people with mental illness and disability this means that both frameworks will apply and be required to continue to operate alongside each other.

The MHT agreed that the Act is difficult to understand, even for those people who use it on a frequent basis and queried whether the Act could be simplified through the use of Regulations.

Education and Training

Several respondents commented on education and training.

One respondent commented on the need for a Plain Language Guide to the Act and suggested that the Consultation Document could form the basis for such a document. The respondent noted that improved education, training and accreditation in respect of Act use will improve the consistency and efficiency of the Act's interpretation and use and would greatly assist consumers, family members, carers, clinicians, managers and other people tasked with administration and oversight of the Act. The respondent commented that the most relevant part of the Act may be "to give everyone involved in such assessment and treatment clear direction as to their rights and responsibilities". The respondent expressed the view that creation of a single document that could be stored in one place and updated as necessary would make the Act easier to absorb and apply and overcome problems of corporate memory.

Another respondent noted that it would be great "in the heat of the moment" to have a quick reference sheet to guide decision making.

The LACT commented on the lack of education opportunities between the Tasmanian Health Service, the MHT and the LACT and expressed the view that this would be of significant benefit to the sector and people affected by the Act.

In terms of education and training for consumers, several respondents suggested the need for simple information about the Act that is easy to understand. Respondents noted that consumers often feel overwhelmed by the amount of information provided to them and often disregard it. A staff member of the Tasmanian Health Service suggested the use of visual information such as pictures or video messages rather than verbal information or text to assist people with cognitive issues or poor literacy. The staff member also suggested that peer workers may be a source of guidance on how best to educate patients.

Resourcing

A number of respondents provided feedback on the resourcing required to administer the Act.

Comments made by one respondent suggested the need to provide greater administrative support to staff within the Tasmanian Health Service out of usual business hours. Another respondent noted the use of technological solutions in other health services including the use of digital verification keys which allow forms to be signed off over the phone.

Several staff of the Tasmanian Health Service commented on the number of medical practitioners required to comply with the Act's requirements and noted that in smaller centres this creates stress for clinical staff with one respondent suggesting the need to amend the Act to allow medical practitioners who are not approved, or senior nurses, to "sign off" on some matters.

The MHT expressed the view that the Act has placed significant pressure on approved facilities and suggested that this appears to be because the vast majority of patients who come under the Act are admitted and detained, initially under authority of Assessment Orders which require the patient's detention. The MHT queried the Act's application to private sector patients and facilities and noted that even if only a small number of private patients came under the jurisdiction of the Act, this would have the potential to ease the pressure currently being experienced in the public sector.

The MHT noted that a significant proportion of patients who are admitted and detained in an approved hospital initially under authority of an Assessment Order or for failure to comply or to prevent possible harm are brought in by ambulance or police and queried the pressure the Act places on Tasmania Police and Ambulance Tasmania. The MHT also queried the requirement for ambulance officers and police to spend long periods at approved facilities waiting for the person's custody to be handed over.

As noted above, the MHT's submission noted the resourcing required to support the Act and on the "significant shortfall in resources" for representation of patients at hearings, with 77 per cent of patients unrepresented in civil hearings and 62 per cent unrepresented in forensic hearings. The MHT expressed the view that these figures are too high given the Act's focus on patient rights.

The Northern FLAG commented on the lack of continuity of care and specialist medical treatment in Tasmania. The Northern FLAG also suggested the need for a safer, more gentle and welcoming system for inpatients, especially in Emergency Departments.

The RANZCP Tasmanian Branch commented on the AMP role and expressed concern that AMPs, who (in the Branch's view) will and do vary in experience and qualifications, are effectively the only group of medical practitioners specified under the Act for the assessment and treatment of people with mental illness. The Branch noted that the Act does not mandate the involvement of a psychiatrist in a patient's care and suggested that it is possible to see that a patient may proceed through assessment, admission and discharge under the Act without seeing a treating psychiatrist, except the psychiatrist on the MHT, and it is not the role of that psychiatrist to undertake formal assessment and management. This is because involvement of a psychiatrist is not mandated under the Act.

Searching

One respondent commented on the Act's search provisions and suggested that these should be expanded to cover all patients under the Act. Current practice is to conduct searches in relevant circumstances and the practice is considered important for both staff and patient safety. The respondent suggested the inclusion of provisions enabling searching in set circumstances to address this issue.

Advance Care Directives

Several respondents commented specifically on Advance Care Directives, with one respondent querying why the mental health system fails to recognise Advance Care Directives and another suggesting that the Act should recognise the use of Advance Care Directives in mental health.

Interaction with *Firearms Act 1996* (Tas)

Tasmania Police provided feedback suggesting the need to do more to promote the mandatory reporting requirements under sections 148 and 158A of the *Firearms Act 1996* (Tas) to medical practitioners who are involved with assessing patients under the Act. Tasmania Police highlighted that in the past 18 years more than 200 Tasmanians have taken their lives using a firearm and that promotion of these sections has been identified as a way of reducing the risk of suicide by firearm.

Tasmania Police suggested a number of ways that the requirements of these sections could be promoted including:

- Inserting a section to the Act that mirrors section 148 of the *Firearms Act.*
- Adding references in the Act to the requirements of section 148 of the *Firearms Act* and requiring the terms of section 148 to be addressed by a medical practitioner when assessing a patient.
- Including a requirement to refer to section 148 in Standing Orders or Clinical Guidelines issued by the Chief Psychiatrists.
- Including "firearms clauses" similar to those contained in Family Violence Orders in Treatment Orders, where appropriate. Such provisions would have effect to preclude the person from having firearms or applying for a firearms license while subject to the Order.

Social Determinants of Health

One respondent commented on the social determinants of health approaches to improve community health and wellbeing and economic productivity and suggested the need to recognise these by upholding the human right to liberty and embedding preventative measures on restrictive practices in mental health facilities

Review Outcome 29:

The Act's drafting can be improved to increase clarity and understanding.

Consideration should be given to improved support for advance care directives, searching, and obligations that exist under the *Firearms Act 1996*.

There is a need for improved and increased education and training and resourcing to support the Act's operation.

19.4.2 Government Response

Feedback received on the extent to which the Act is operating to maximise and promote consumer involvement in decision-making while facilitating the involvement of carers and family members to the extent that this is consistent with the consumer's wishes, and with respect to offences and immunities, remote medical procedures, powers of sedation, conflicts of interest, the correction of orders and other aspects of the Act's operation are noted.

The inclusion of provisions authorising searches of involuntary patients was considered during the Act's development. Provisions for this purpose were not included as they were not considered to sit comfortably with the Act's objects or Mental Health Service Delivery Principles. There was also some concern that their inclusion was inconsistent with a therapeutic approach and may constitute unjustifiable discrimination on the basis of disability in breach of the CRPD. They were omitted from the legislation for these reasons.

Section 218 of the Act is broadly reflective of immunity provisions in other legislation including section 92 of the *Mental Health Act 1996* and section 41 of the *Ambulance Service Act 1982*. It is also generally consistent with Employment Direction No. 16 issued under the *State Service Act 2000* and with the Policy and Guidelines for the Grant of Indemnities and Legal Assistance to Public Officers of the State of Tasmania that sits underneath that Direction.

While the inclusion of provisions for advance care directives was carefully considered during the Act's development this approach was ultimately not adopted. Advance care directives are relevant for all health consumers, not just those with mental illness and the Government's approach at the time was to consider the issue at a broad health care level for all health consumers.

As noted earlier in this document, the TLRI's recommendations following its review of the *Guardianship and Administration Act* include a recommendation that Tasmania adopts a legislative framework for advance care directives and that this be included in the *Guardianship and Administration Act*. The Government's views on the Institute's recommendations will be considered in due course.

Government Response to Review Outcomes 26, 27, 28 and 29:

Legislative Response

The Government will amend the Act to make it less confusing and easier to navigate and to address other issues raised by stakeholders that have not been covered elsewhere in this document. As part of this process the Government will consider the extent to which matters that are currently provided for in the Act, could be moved to regulations.

The Government will amend sections 224 and 224A of the Act (relating to correction of documentation) so that they are easier to understand and use. As part of this process the Government will consider amending the sections to provide 14 days in which documentation issues can be fixed and to enable the person who made the error to correct it.

The Government will amend the Act and make consequential amendments to inserting legislation where necessary to ensure consistency in terminology and operation.

The Government will review legislative and other options for emphasising the requirements of section 148 of the *Firearms Act.* As part of this process the Government will consider amending the Act to require medical practitioners to consider the terms of section 148 of the *Firearms Act* when conducting an assessment under the Act or confirming the ability for the MHT to include a "firearms clause" precluding a person from having or applying for a firearm in a Treatment Order.

The Government will seek expert clinical, legal and other advice on whether the Act should be amended to enable all patients under the Act to be searched. As part of this process the Government will consider the extent to which the inclusion of punitive strategies such as search powers is consistent with a therapeutic approach and with the Act's objects and Mental Health Service Delivery Principles, and with provisions of the CRPD.

The Government will also seek expert legal advice on whether the Act should be amended to modify or remove section 218.

The Government will consider amendments to legislate for advance care directives for people with mental illness as part of its consideration of the TLRI's recommendations following the TLRI's review of the *Guardianship and Administration Act*.

Education and Training Response

The Government will develop and deliver education and training to clinicians and others in the requirement to tell carers about matters that are relevant to the person for whom they have caring responsibilities including seclusion and restraint episodes, patient discharge, appointment times and attendance issues.

The Government will develop and deliver education and training to clinicians and others to ensure that carer inclusion is viewed and standard practice and to emphasise the need to listen to carers in their efforts to advocate for themselves and the person they care for to ensure that carers to do feel that the information they have about the person they care for is heard and is valued. As part of this process the Government will consider the MHHITH model of carer inclusion as a model for adoption throughout the Tasmanian Health Service.

The Government will consider new ways to engage with carers and to provide them with information about the Act and intersecting legislation such as the *Guardianship and Administration Act*.

In developing and delivering education and training the Government will adopt a collaborative approach involving key stakeholders including the LACT, MHT, Official Visitors and the Chief Psychiatrists.

Documentation and Processes Response

The Government will develop a Plain English Guide to the Act to enhance understand of its provisions and a Quick Reference Guide to decision-making under the Act.

In developing new documentation associated with the Act, the Government will consider new ways of communicating including the use of visual information such as pictures or video messages, and increased use of peer workers.

The Government will identify better processes for communicating when an order is made under the *Criminal Justice (Mental Impairment) Act* or *Sentencing Act* to ensure that the MHT and members of the treating team know that an order has been made and what it provides for.

Resource-Related Response

The Government will consider any funding submissions in relation to this Review Outcome, through future Budget processes.

Appendix A Review Outcomes

Review Outcome 1:

For at least some people, the Act's provisions are not being interpreted and applied in a way that promotes its objects.

Reasons given for this include a perceived lack of alignment between the Act's objects and its provisions, poor understanding of the Act's provisions, omission of voluntary patients from the Act's scope and broader issues affecting the health system in Tasmania.

Review Outcome 2:

People exercising responsibilities under the Act are not always doing so in a way that has regard to the Mental Health Service Delivery Principles.

Reasons given for this are similar to the reasons relating to Outcome 1 and include a perceived lack of alignment between the Act's principles and its provisions, difficulties in understanding the Act's requirements due to its complexity and structure, lack of a human rights culture that promotes health and well-being for individuals and community and respect and dignity for people who are unwell.

Review Outcome 3:

While the test for decision-making capacity contained in the Act is generally considered to be appropriate there is some concern about how the test is operating.

The main reason for this appears to be the lack of a good or shared understanding about the requirement for decision-making capacity to be presumed and about how the test should be interpreted and applied in practice.

Review Outcome 4:

The meaning of mental illness set out in section 4 is operating as intended. It is easy to understand and apply but could be made easier for at least some people with better education and training and if minor changes were made to the drafting.

Review Outcome 5:

While the assessment framework established by the Act is, in general, operating effectively and efficiently, there are aspects of the framework that could be better understood and applied in ways that are more inclusive of consumers and carers. There are additionally some issues with the terminology used to describe processes associated with assessments.

While some people think that the Act should specifically regulate, or prevent, assessment without informed consent or an Assessment Order this view is not shared by others.

Review Outcome 6:

Provisions for Assessment Orders are not operating effectively nor are they easy to understand and apply.

Reasons for this include lack of clarity about the circumstances in which a person who is subject to an Assessment Order may be provided with treatment unless urgent circumstances treatment is authorised, difficulty meeting the timeframes set out in the Act for the making and affirmation of Assessment Orders and Treatment Orders, and lack of clarity in the Act's provisions.

Review Outcome 7:

While the treatment framework established by the Act is operating more effectively than the framework established by the *Mental Health Act 1996*, there is a need for greater clarity in some aspects of the framework, including the circumstances in which a person who is subject to the Act's protective custody provisions or is under an Assessment Order may be given emergency treatment, and the role and purpose of treatment plans.

Review Outcome 8:

At least for some people, provisions of the Act for Treatment Orders are not operating effectively nor are they easy to understand and apply.

Reasons for this include a lack of clarity and absence of a shared understand about various matters associated with Treatment Orders including assessment requirements preceding an application being made, the criteria that should apply to be placed on a Treatment Order, the way that Treatment Orders authorise treatment, discharge and renewal, and readmission processes and requirements.

Review Outcome 9:

No issues with the operation, understanding or application of the special psychiatric treatment provisions of the Act were identified.

Review Outcome 10:

In the view of many, the Act is not operating effectively to facilitate treatment for children.

Reasons for this include difficulties in applying the Act's provisions where there is no parent available or willing to provide consent; lack of clarity around who can provide consent to assessment or treatment for a child who lacks decision-making capacity; lack of oversight available to children who are assessed or treated with the informed consent of a parent; and lack of coherence in the Act's provisions that relate to children.

Review Outcome 11:

While provisions of the Act relating to involuntary patient transfers and leaves of absence are clear and easy to understand they do not always operate effectively.

Reasons for this include staff practices and procedures, the cumbersome nature of the requirements imposed by the Act and (in the case of absence without leave), lack of adequate supporting processes.

Review Outcome 12:

Involuntary patients are often not being afforded the rights referred to in the Act.

Reasons for this include difficulty in identifying the rights that patients have under the Act, lack of understanding on the part of patients and staff about those rights, staff practices and processes and lack of accountability mechanisms within the legislation for staff to afford patients the rights they are required to be afforded under the legislation.

Review Outcome 13:

Provisions for the admission and detention of people to the secure mental health unit are not operating effectively in all cases.

The main reason for this is lack of clarity in the Act's provisions.

Review Outcome 14:

Provisions for forensic patient movements and forensic patient leave are generally operating effectively and efficiently and are clear and easy to understand.

Resourcing, and the capacity for therapeutic and rehabilitation leave to be granted and prioritised, are issues for at least some forensic patients and their families.

Review Outcome 15:

Provisions for the treatment of forensic patients are generally operating effectively and efficiently and are clear and easy to understand.

Issues exist with respect to the treatment of people who are prisoners and for at least some stakeholders, the interface between involuntary treatment and restriction orders is problematic.

Review Outcome 16:

Provisions for the management of forensic patients and the secure mental health unit are operating effectively and efficiently and are clear and easy to understand.

For at least some people, the privatisation of security services and the way in which risk is managed as part of the care that is provided to forensic patients with significant history are issues.

Review Outcome 17:

Forensic patients are being afforded the rights referred to in the Act.

Review Outcome 18:

The seclusion and restraint provisions of the Act are not operating effectively and efficiently.

Reasons for this include lack of clarity in the Act's provisions, inadequate facility design, and lack of clear understanding about the Act's requirements with respect to seclusion and restraint.

Review Outcome 19:

The protective custody and escort components of the Act do not always operate effectively nor are they always clear and easy to understand. In particular, and for at least some people, the time period in which a person may be held in protective custody following arrival at an approved assessment centre is too short.

Reasons underpinning the reported ineffective operation of the provisions include lack of clarity in the Act's provisions, lack of understanding on the part of at least some people about the Act's provisions and requirements, and inadequate resourcing.

Review Outcome 20:

Provisions for the approval and authorisation of facilities and people are operating effectively and efficiently.

Issues exist with the nature of facilities that are approved, the number of people that are approved and the education and training available and provided to people who are approved or who are seeking approval.

Review Outcome 21:

Provisions of the Act for information management and record keeping are generally operating effectively and efficiently but could be improved if they were extended to voluntary patients, were applied with reference to available technologies to improve the provision of information to patients, and if they facilitated greater information sharing in relevant circumstances.

Review Outcome 22:

Provisions of the Act for the establishment, powers and functions of the MHT are operating effectively and efficiently.

At least some respondents have some issues with forms required to be used under the Act, including forms that have been approved by the President of the MHT for use under the Act.

Review Outcome 23:

At least for some people, provisions of the Act for the MHT's proceedings and determinations are not operating effectively and efficiently. For those people, there is a view that some aspects of the Tribunal's practices and approaches could be reviewed.

Review Outcome 24:

Provisions of the Act for the appointment, powers and functions and other matters associated with Official Visitors are operating effectively and efficiently but could be improved with some minor changes to the Act's provisions to clarify the powers and functions of Official Visitors with respect to people who have not expressed a wish to see or complain to an Official Visitor, and children, through greater education and training of consumers and carers around the role and function of Official Visitors, and through increased resourcing.

Review Outcome 25:

Provisions for the appointment, powers and functions and other matters associated with the Chief Psychiatrists are operating effectively and efficiently.

There are issues with the forms approved by the Chief Psychiatrists for use under the Act including that they are difficult to use, time consuming and stressful to complete, hard to find and overly complex, and cannot be completed online.

Review Outcome 26:

For at least some people, the Act is not operating as intended to maximise and promote consumer involvement in decision-making while facilitating the involvement of carers and family members to the extent that this is consistent with the consumer's wishes.

Reasons for this include lack of resources and the culture and attitude of staff.

Review Outcome 27:

Provisions of the Act relating to offences and immunities are operating effectively and efficiently except with respect to section 218 of the Act, which is viewed as preventing accountability and transparency with respect to actions of staff and clinicians under the Act.

Review Outcome 28:

Provisions of the Act relating to remote medical procedures, powers of sedation, conflicts of interest and the correction of orders are operating effectively and efficiently for most people.

Review Outcome 29:

The Act's drafting can be improved to increase clarity and understanding.

Consideration should be given to improved support for advance care directives, searching, and obligations that exist under the *Firearms Act 1996*.

There is a need for improved and increased education and training and resourcing to support the Act's operation.

Appendix B Government Response to Review Outcomes

Government Response to Review Outcome 1:

Legislative Response

The Government will consider amendments to the Act to more clearly link the Act's objects to its operational provisions and to make it easier to understand.

The Government will seek expert clinical, legal and other advice on amending the Act to either narrow its objects so that they align more closely with its provisions or to retain the Act's objects in their current form and make other amendments to extend some of all of the Act's provisions to voluntary patients.

The Government will not consider amendments to the Act to re-insert references to "care". The Government will however consider measures to support the need for holistic care and for care to be provided in a framework that is focussed on respect for human rights, respect and dignity.

Education and Training Response

The Government will develop and deliver education and training to ensure that consumers and people required to work with the Act are aware of their rights and responsibilities including the right to ask the Chief Civil Psychiatrist or Chief Forensic Psychiatrist to directly intervene, and to ask the MHT to conduct a review.

Documentation and Processes Response

The Government will review existing Statements of Rights documentation to ensure that it is clear and easy for patients and others to understand.

The Government will also work to improve processes associated with the movement of patients from more restrictive settings to settings that are less restrictive, and to remove barriers to therapeutic alternatives.

Resource-Related Response

The Government will work to address the impact of broader issues affecting the health system to ensure that the Act's provisions are applied in a way that promotes the Act's objects.

Government Response to Review Outcome 2:

Legislative Response

The Government will consider amendments to the Act to make it easier to understand and to more clearly link the Mental Health Service Delivery Principles to the Act's operational provisions.

The Government will also consider amendments to ensure that the Mental Health Service Delivery Principles remain contemporary and to include the Mental Health Service Delivery Principles in the body of the Act rather than in a Schedule. Amendments that may be considered as part of this process include amendments to more clearly demonstrate what the right to dignity, self-respect, liberty, autonomy and other inherent rights look like, amendments to reference sexual safety and rehabilitation and trauma-informed policy and process, and amendments to emphasise the Government's obligation to actively respect, promote and fulfil human rights.

Education and Training Response

The Government will develop and deliver education and training to clinicians and others on the Mental Health Service Delivery Principles to support clinicians who are required to exercise responsibilities under the Act to do so in a way that has regard to the Principles, promoting health and wellbeing for individuals and the community, and respect and dignity for people who are unwell.

Government Response to Review Outcome 3:

Legislative Response

The Government will review the Victorian Supreme Court's decision in *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 (1 November 2018, revised 22 January 2019), the findings and recommendations of Coroner McTaggart following the holding of an inquest under the Tasmanian *Coroner's Act 1995* into the death of Edward Paisley Peck (26 September 2019) and any other relevant judgments and seek expert legal, clinical and other advice to determine how a person's decision-making capacity should be assessed. The Government will consider amendments to the test for decision-making capacity contained in the Act should this be considered necessary as a result of these processes.

The Government will consider the need to amend the Act to refer to "decision-making ability" and to reflect concepts of supported decision making as part of the Government's consideration of and response to the TLRI's recommendations following its review of the *Guardianship and Administration Act 1995*.

Education and Training Response

The Government will develop and deliver education and training to ensure that clinicians who assess decision-making capacity promote voluntary over involuntary treatment and the exercise of free choice by ensuring that consumers are provided with enough explanation and information about diagnosis and treatment options and time in which to ask questions and consider the information and options, and the opportunity to get a second opinion.

The Government will develop and deliver education and training to ensure that clinicians have a better understanding in practice of what the meanings of informed consent and decision-making capacity mean when referred to in the Act so that people who have capacity and refuse consent are not treated involuntarily.

The Government will develop and deliver education and training to ensure that clinicians understand the requirement to start from a presumption that a person with mental illness has decision-making capacity rather than the opposite.

The Government will develop and deliver education and training with input from all stakeholders to ensure more consistent application of the test for decision-making capacity at every stage of a person's assessment and treatment pathway.

The Government will also develop and deliver education and training on the importance of speaking with family members and others when assessing a person's decision-making capacity.

Documentation and Processes Response

The Chief Psychiatrists will consider amending Chief Civil Psychiatrist and Chief Forensic Psychiatrist Clinical Guideline 2 – Decision-Making Capacity to increase clarity of understanding about how the test for decision-making capacity should be applied in practice.

Government Response to Review Outcome 4:

Legislative Response

The Government will consider amending the meaning of mental illness so that it is easier to understand.

The Government will review relevant legislation in place in New South Wales to identify how the term "mental disorder" is used and to assess whether there is merit in adopting the term in the Act.

Education and Training Response

The Government will develop and deliver education and training to assist in the Act's application to people with dementia and delirium.

Documentation and Processes Response

The Chief Psychiatrists will consider amending Chief Civil Psychiatrist Clinical Guideline 1 – Meaning of Mental Illness to confirm that it is not necessary for a person's to have a diagnosed mental illness to come within the meaning of the Act and to clarify how the meaning applies to people who are intoxicated and whose behaviour "mimics" psychosis.

Government Response to Review Outcomes 5 and 6:

Legislative Response

The Government will consider amending the Act to clarify and distinguish between the terms "examine", "examination", "monitor", "evaluate" and "assessment" and to ensure that language used to describe assessments is clear and consistent.

The Government will consider amending the Act to more clearly identify the circumstances in which a person who is subject to an Assessment Order may be provided with treatment.

The Government will consider amending the Act to more clearly identify whether, and if so the circumstances in which, a second Assessment Order may be made.

The Government will consider amending the Act to clarify timeframes associated with Assessment Orders and requirements around provision of documentation to patients and others including at the point that an Assessment Order is affirmed.

The Government will seek expert clinical, legal and other advice to determine whether the Act should be amended to specifically regulate, or prevent, assessment without informed consent or an Assessment Order.

Education and Training Response

The Government will develop and deliver education and training to assist clinicians to better understand and apply the Act's provisions as they concern assessment and Assessment Orders and to explain the Act's provisions to consumers and carers.

The Government will develop and deliver education and training to support the inclusion of carers and consumers in assessment processes.

Documentation and Processes Response

The Government will identify ways to improve processes for ensuring that patients are provided with copies of Assessment Orders, Statements of Rights and other key information.

Resource-Related Response

The Government will consider any funding submissions in relation to this Review Outcome, through future Budget processes.

Government Response to Review Outcomes 7, 8 and 9:

Legislative Response

The Government will amend the Act to retain the requirement for Treatment Plans to be developed and in place for involuntary patients but to change the requirement for a copy of the Plan to be provided to the MHT.

The Government will consider amending the Act to more clearly identify the circumstances in which a person who is in protective custody or subject to an Assessment Order may be provided with treatment.

The Government will amend the urgent circumstances treatment provisions of the Act (sections 55 and 87) to make them clearer and easier to understand and to ensure that they may more clearly be used for a person who has not yet been diagnosed with mental illness or assessed with respect to this.

The Government will amend the Act to clarify what is meant in section 37 by the requirement for the applicant and another approved medical practitioner to have separately assessed the person for whom a Treatment Order is considered to be required and to preclude the requirement for this requirement to be met through an overheard conversation.

The Government will amend the Act to clarify whether an interim Treatment Order can be extended by the MHT if a matter is adjourned.

The Government will amend relevant sections of the Act to clarify the matters that must be included in a Treatment Order. As part of this process the Government will consider whether a Treatment Order should refer to types of medications or accommodation. The Government will also consider amendments to clarify "treatment setting" and the circumstances in which a patient may be returned to hospital and the criteria for this.

The Government will amend the Act to clarify how a Treatment Order may be discharged when it is not possible to determine whether the patient meets the treatment criteria because, for example, the patient's location is unknown.

The Government will amend the Act to clarify matters associated with the renewal of Treatment Orders including how long before an Order expires an application for renewal needs to be lodged, whether it should be a requirement for a patient's treating medical practitioner to tell a patient that they are being assessed with respect to an application for renewal and to confirm whether a renewed Treatment Order is a new Order, or an extension of an existing Order.

The Government will consider amending section 16(2) of the Act to confirm that the phrase "with informed consent" includes informed consent provided by a parent under section 9 of the Act and to clarify how parts (i), (ii) and (iii) of the subsection operate to authorise treatment for involuntary patients.

The Government will also consider amending the timeframes associated with applications for Treatment Orders to make them easier for clinicians to meet.

The Government will seek expert clinical, legal and other advice to determine whether the Act should be amended to confirm that "treatment" includes anticholinergics, ongoing assessment against the assessment criteria, and a requirement for patients to undergo drug screening tests.

The Government will also seek expert clinical, legal and other advice to determine whether the treatment criteria should be amended to remove references to the need for treatment, the appropriateness and effectiveness of the treatment and the risk to the person or others if treatment is not provided. As part of this process the Government will seek advice on whether there is a need to clarify what the terms "serious harm" and "risk" mean, and how the Act can be amended to move away from a "best interests" approach.

Education and Training Response

The Government will develop and deliver education and training to assist clinicians and others to apply the Act's provisions consistently across service settings.

The Government will develop and deliver education and training to assist clinicians and others to understand the circumstances in which a person who is under protective custody or subject to an Assessment Order may be provided with treatment.

The Government will develop and deliver education and training to clarify for clinicians and others when and how urgent circumstances treatment may be authorised and to confirm that this will not always be at the same time as a person is placed on an Assessment Order.

The Government will develop and deliver education and training to support clinicians to write Treatment Plans.

Documentation and Processes Response

The Chief Civil Psychiatrist will review forms for the readmission of patients to approved facilities to ensure that they are clear and easy to understand and complete.

The Chief Civil Psychiatrist will consult with the SHPA to confirm whether the SHPA is aware of the Chief Civil Psychiatrist's Clinical Guideline 7 Off-Label Use of Medications and to see whether the SHPA can suggest any changes that may need to be made to the document to ensure that it is clear and easy to understand, and fit for purpose.

The Tasmanian Health Service will review processes for involuntary patients whose treatment is provided across treatment settings to ensure that community-based members of a patient's treating team are involved in Treatment Order processes at an early point in time and before the patient's discharge to the community.

Resource-Related Response

The Government will consider any funding submissions in relation to this Review Outcome, through future Budget processes.

Government Response to Review Outcome 10:

Legislative Response

The Government will consider amending the Act to make the Act's provisions as they apply to children easier to read and understand. As part of this process the Government will consider amalgamating existing provisions to a new Part that applies specifically to children and developing Mental Health Service Delivery Principles that apply specifically to children.

The Government will consider amending the Act to clarify how a child can be assessed and treated in circumstances where there is no person with parental responsibility willing or able to provide consent.

The Government will consider amending the Act to address the needs of children who are particularly vulnerable. As part of this process the Government will consider mechanisms to mandate the involvement of a child advocate in assessment and treatment decisions.

The Government will seek expert clinical, legal and other advice to determine whether the Act should be amended to either change the status of children for whom consent is given by a parent so that they are no longer considered "voluntary" or to extend protections that apply to involuntary patients to children who are being assessed or treated with consent from a parent.

Education and Training Response

The Government will develop and deliver education and training to assist clinicians to better understand and apply the Act's provisions as they concern children.

The Government will develop and deliver education and training to support the inclusion of parents in assessment and treatment processes and to ensure that parents are provided with access to relevant documentation.

Documentation and Processes Response

The Government will identify ways to improve processes for ensuring that patients are provided with copies of Assessment Orders, Statements of Rights and other key information.

Resource-Related Response

The Chief Psychiatrists will consider developing a Standing Order or Clinical Guideline explaining the Act's provisions as they apply to children.

Government Response to Review Outcomes 11 and 12:

Legislative Response

The Government will amend the Act to streamline and simplify leave and patient transfer provisions.

The Government will also consider amending the Act to harmonise involuntary patient rights and forensic patient rights, and to ensure that the rights that are set out in the Act remain contemporary.

Education and Training Response

The Government will develop and deliver education and training to ensure that clinicians and others are aware of the requirement to provide patients with Statements of Rights and copies of relevant documentation, including in respect of leave decisions, at key points in time.

The Government will develop and deliver education and training to support clinicians to conduct risk assessments with respect to decisions to allow involuntary patients to be granted leave, and to take leave that has been granted.

Documentation and Processes Response

The Government will identify ways to ensure that patients are provided with Statements of Rights and copies of other relevant documentation, including in respect of leave decisions, at key points in time.

The Government will review Statements of Rights to ensure that they are understandable in all situations and clearly identify the leave options available to involuntary patients under the Act and the right for involuntary patients to be provided with copies of relevant documentation.

The Chief Civil Psychiatrist will review Chief Civil Psychiatrist Approved Forms relating to leave to reduce and simplify the documentation that needs to be completed when documenting leave.

The Chief Civil Psychiatrist and the Mental Health Tribunal will review documentation associated with Assessment Orders and Treatment Orders respectively to ensure that they are easy for involuntary patients, carers and others to understand and interpret.

Resource-Related Response

The Government will consider any funding submissions in relation to this Review Outcome, through future Budget processes.

Government Response to Review Outcomes 13, 14, 15, 16 and 17:

Legislative Response

The Government will amend the Act to clarify and streamline admission and discharge mechanisms for prisoners and detainees and youth detainees requiring admission to or discharge from a secure mental health unit. As part of this process the Government will consider the need for amendments to intersecting legislation including the *Corrections Act 1997* and *Youth Justice Act 1997*. The Government will also consider the need for amendments to clarify the Act's provisions as they concern prisoners and detainees, and youth detainees, and people who are discharged from prison or youth detention in general terms.

The Government will also amend the Act to clarify and streamline admission, re-admission, detention and discharge mechanisms for involuntary patients requiring admission (or re-admission) to, or discharge from, a secure mental health unit.

The Government will consider amendments to the Act to harmonise terminology and treatment pathways that apply to involuntary patients and forensic patients.

The Government will consider any amendments to the criteria for treatment for forensic patients set out in the Act as part of the Government's consideration of the TLRI's Final Report following the TLRI's review of the Defence of Insanity in section 16 of the *Criminal Code Act 1924* and fitness to plead.

The Government will seek expert clinical, legal and other advice to determine whether the Act should be amended to provide authority for telephone calls made to or from forensic patients to be monitored.

Education and Training Response

The Government will develop and deliver education and training to assist clinicians to better understand and apply the Act's provisions as they concern prisoners.

The Government will develop and deliver education and training to support clinicians to conduct risk assessments with respect to decisions to allow forensic patients to take leave that has been granted.

The Government will also develop and deliver education and training to assist carers to better understand the role and function of all members of a forensic patient's treating team.

Documentation and Processes Response

The Government will review processes for the conduct of reviews of patients who are subject to Treatment Orders and who are detained, at the time of the review, in prison.

The Government will review processes for forensic patient leave programs to ensure continuity of leave programs and to ensure that patients who have been granted leave can take it to the maximum extent possible in the circumstances.

The security procedures in place at the Wilfred Lopes Centre were reviewed by the Tasmanian Health Service in 2019 as part of the Government's response to the Prisoner Mental Health Care Taskforce Final Report and found to be appropriate. No further action is considered to be required.

Resource-Related Response

The Government will consider any funding submissions in relation to this Review Outcome, through future Budget processes.

Government Response to Review Outcome 18:

Legislative Response

The Government will amend the Act to streamline the seclusion and restraint provisions to make them easier to understand and more consistent with other provisions of the Act. As part of this process the Government will consider amendments to remove the ability for a person to be secluded to provide for the management, good order or security of an approved hospital.

The Government will also amend the Act to clarify the use of short-term physical restraint and to distinguish this from physical restraint that is required to be authorised under and regulated by the Act. As part of this process the Government will seek expert clinical, legal and other advice on the need for amendments to the Act to regulate the use of force/short term restraint with respect to people who are in protective custody and/or restrained for "duty of care" type reasons.

The Government will consider amendments to either prevent or more closely regulate the use of mechanical or chemical restraint and to reduce the use of seclusion in approved facilities.

Education and Training Response

The Government will develop and deliver education and training to assist clinicians and others to better understand and apply the Act's provisions as they concern seclusion and restraint, including the observation and other timeframes that apply and record keeping requirements.

The Government will develop and deliver education and training to support clinicians to distinguish between chemical restraint and treatment, and to conduct risk assessments with respect to patients who are in suicidal distress and considered to require seclusion or restraint.

Documentation and Processes Response

The Government will consider replacing canvas blankets used in seclusion rooms with cotton blankets, and alternatives to the use of security guards and orderlies to assist with restraint.

The Chief Psychiatrists will amend those of the Chief Psychiatrists' Standing Orders and Clinical Guidelines that apply to restraint to more clearly distinguish chemical restraint from treatment.

The Chief Psychiatrists will also review and revise the Chief Psychiatrists' Approved Forms for seclusion and restraint to make them less repetitive and onerous to complete, particularly in situations where a person is both secluded and restrained.

Resource-Related Response

The Government will consider any funding submissions in relation to this Review Outcome, through future Budget processes.

Government Response to Review Outcome 19:

Legislative Response

The Government will review and amend the protective custody provisions in the Act to make them more readily applicable to people who are already at an approved assessment centre when the need to take the person into protective custody becomes apparent.

The Government will seek expert clinical, legal and other advice on the need to amend the Act to alter the time for which a person who has been brought to an approved assessment centre in protective custody may be held at the centre.

Education and Training Response

The Government will develop and deliver education and training to assist clinicians to better understand and apply the Act's provisions as they concern protective custody and escort functions. Education and training that is developed and delivered will clarify the obligation for MHOs who are based in Emergency Departments to comply with requests from police officers and other MHOs to accept the protective custody of a person where that custody is handed over, in relevant circumstances. Education and training will also clarify the requirement to release a person from protective custody after four (4) hours and provide guidance on the steps that should be taken to address the situation of people who are unwell when they are released from protective custody.

Documentation and Processes Response

The Tasmanian Health Service will review processes surrounding protective custody to ensure that police officers are not used routinely as "first responders" and escorts of people with mental illness.

The Tasmanian Health Service will also review processes surrounding the handover of protective custody to ensure that police officers can hand over a person's protective custody in a timely manner when this is required.

Resource-Related Response

The Tasmanian Health Service will work to ensure that more mental health clinicians and Emergency Department staff are approved as MHOs.

Government Response to Review Outcome 20:

Education and Training Response

The Government will develop and deliver education and training for MHOs, AMPs, approved nurses and others in their responsibilities and obligations under the Act. Education and training that is developed and delivered will clarify the obligation for MHOs who are based in Emergency Departments to comply with requests from police officers and other MHOs to accept the protective custody of a person where that custody is handed over, in relevant circumstances.

Resource-Related Response

The Tasmanian Health Service will work to ensure that more Emergency Department staff are approved as either medical practitioners or MHOs, as relevant.

Government Response to Review Outcome 21:

Legislative Response

The Government will amend section 114 of the Act to include the Principal Official Visitor as a body to whom the controlling authority is to give records.

The Government will consider amending section 134 of the Act to enable information to be disclosed to the Department of Education with respect to students with complex mental health needs, and to the National Disability Insurance Scheme Quality and Safeguards Commission and National Disability Insurance Agency in relevant circumstances.

The Government will also consider amending section 134 of the Act to extend its application to information of a confidential or personal nature that is obtained about a voluntary patient.

Education and Training Response

The Government will develop and deliver education and training to clinicians and others to reinforce the requirement for patients and others to be given information in a language and form that the person can understand.

The Government will deliver education to consumers, families, friends and carers to ensure they are aware of the complaints process and the avenues available to them to resolve complaints and allegations.

Documentation and Processes Response

In reviewing existing documentation and developing new documentation associated with the Act, the Government will consider new ways of communicating including the use of visual information such as pictures or video messages, available technologies such as iPads, and increased use of peer workers.

The Government will also consider the need for key documentation including Statement of Rights to be translated into languages other than English.

Government Response to Review Outcomes 22 and 23:

Legislative Response

The Government will consider amending the Act to address feedback provided by the MHT which suggests that many reviews may be ineffective because they occur at a point when the outcome of the review can have little impact on the matter the subject of the review.

The Government will, following further consultation with the MHT and Principal Official Visitor, consider amending the Act to enable the Tribunal to refer matters that are raised with it to the Principal Official Visitor, and to enable the Principal Official Visitor to conduct a preliminary inquiry.

The Government will consider amending the Act to alter the circumstances in which the MHT may refuse to review a matter that it has been asked to review by a patient or other person, to reduce the number of reviews that are sought but refused because the MHT has concluded a review of the same matter within the preceding three (3) months, or because there is nothing in the application to indicate that there has been any material change in the relevant circumstances since the previous review.

Education and Training Response

The MHT will develop and deliver education and training for patients, carers, advocates and others on the MHT's functions and mode of operation including how to ask the MHT for a review and how to access advocacy and legal representation.

The MHT will also develop and deliver education and training for clinicians and others about the role of the psychiatrist member of the MHT, and on the MHT's role as a decision-making and oversight body.

Lastly the MHT will develop and deliver education and training for MHT members to assist them to ensure that hearings are conducted in a manner that is less confronting to and inclusive of staff, consumers and carers.

Documentation and Processes Response

The MHT will review relevant MHT-approved forms to make them more consistent in format.

The Government will explore options to enable all MHT-approved forms to be completed online.

The MHT will review its processes to identify how proceedings can be made less confronting to staff, consumers and carers and to reduce the need for patients to "tell their story" more than once.

The MHT and Tasmanian Health Service will review their processes to facilitate access by advocates and legal representatives to patient files before hearings.

The MHT and Tasmanian Health Service will work together to facilitate greater involvement of members of the patient's treating team other than the patient's treating medical practitioner in Tribunal hearing processes.

The MHT will identify ways to ensure that carers and others are provided with notice of hearings as far in advance of the hearing as possible.

Lastly, the MHT will identify ways to provide patients who are acutely unwell with an understanding of the reasons for decisions immediately after hearings. The MHT will also consider including findings of fact and law and other relevant matters in statements of reasons that are provided after hearings to help patients and others understand the reasons for decisions.

Resource-Related Response

The Government will consider any funding submissions in relation to this Review Outcome, through future Budget processes.

Government Response to Review Outcome 24:

Legislative Response

The Government will amend section 156 of the Act to enable the Principal Official Visitor to raise matters of part concern that come to the Principal Official Visitor's attention with the controlling authority of an approved facility as well as with the responsible Minister or relevant Chief Psychiatrist.

The Government will amend section 165 of the Act to expand the people to whom the Principal Official Visitor may give a private report to include the controlling authority of an approved facility.

The Government will consider amendments to clarify if, and if so how, an Official Visitor should manage complaints that are made by child patients and other voluntary patients.

The Government will also consider amendments to clarify how Official Visitors are to determine whether there has been a contravention of the Act. As part of this process the Government will consider

amendments to section 163 of the Act to extend the obligations set out in it to all people discharging responsibilities under the Act (not just to those people who know that a patient has expressed a wish to see or complain to an Official Visitor), and to enable the Principal Official Visitor to conduct a preliminary inquiry that is referred by the MHT.

Education and Training Response

The Government will develop and deliver education and training to assist carers and consumers to better understand in the role and function of the Principal Official Visitor and Official Visitors.

Documentation and Processes Response

The Government will review Statements of Rights and other documentation to ensure that it clearly identifies how to contact Official Visitors.

Resource-Related Response

The Government will consider any funding submissions in relation to this Review Outcome, through future Budget processes.

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Government Response to Review Outcome 25:

Education and Training Response

The Government will develop and deliver education and training to statutory officers and others in how to complete forms that have been approved by the Chief Psychiatrists.

Documentation and Processes Response

The Chief Psychiatrists will review all Chief Psychiatrist approved forms to make them easier to access, easier and quicker to complete, less repetitive, simpler and more consistent in format.

The Government will explore options to enable all Chief Psychiatrist approved forms to be completed online.

Government Response to Review Outcomes 26, 27, 28 and 29:

Legislative Response

The Government will amend the Act to make it less confusing and easier to navigate and to address other issues raised by stakeholders that have not been covered elsewhere in this document. As part of this process the Government will consider the extent to which matters that are currently provided for in the Act, could be moved to regulations.

The Government will amend sections 224 and 224A of the Act (relating to correction of documentation) so that they are easier to understand and use. As part of this process the Government will consider amending the sections to provide 14 days in which documentation issues can be fixed and to enable the person who made the error to correct it.

The Government will amend the Act and make consequential amendments to inserting legislation where necessary to ensure consistency in terminology and operation.

The Government will review legislative and other options for emphasising the requirements of section 148 of the *Firearms Act.* As part of this process the Government will consider amending the Act to require

medical practitioners to consider the terms of section 148 of the *Firearms Act* when conducting an assessment under the Act or confirming the ability for the MHT to include a "firearms clause" precluding a person from having or applying for a firearm in a Treatment Order.

The Government will seek expert clinical, legal and other advice on whether the Act should be amended to enable all patients under the Act to be searched. As part of this process the Government will consider the extent to which the inclusion of punitive strategies such as search powers is consistent with a therapeutic approach and with the Act's objects and Mental Health Service Delivery Principles, and with provisions of the CRPD.

The Government will also seek expert legal advice on whether the Act should be amended to modify or remove section 218.

The Government will consider amendments to legislate for advance care directives for people with mental illness as part of its consideration of the TLRI's recommendations following the TLRI's review of the *Guardianship and Administration Act*.

Education and Training Response

The Government will develop and deliver education and training to clinicians and others in the requirement to tell carers about matters that are relevant to the person for whom they have caring responsibilities including seclusion and restraint episodes, patient discharge, appointment times and attendance issues.

The Government will develop and deliver education and training to clinicians and others to ensure that carer inclusion is viewed and standard practice and to emphasise the need to listen to carers in their efforts to advocate for themselves and the person they care for to ensure that carers to do feel that the information they have about the person they care for is heard and is valued. As part of this process the Government will consider the MHHITH model to carer inclusion as a model for adoption throughout the Tasmanian Health Service.

The Government will consider new ways to engage with carers and to provide them with information about the Act and intersecting legislation such as the *Guardianship and Administration Act*.

In developing and delivering education and training the Government will adopt a collaborative approach involving key stakeholders including the LACT, MHT, Official Visitors and the Chief Psychiatrists.

Documentation and Processes Response

The Government will develop a Plain English Guide to the Act to enhance understand of its provisions and a Quick Reference Guide to decision-making under the Act.

In developing new documentation associated with the Act, the Government will consider new ways of communicating including the use of visual information such as pictures or video messages, and increased use of peer workers.

The Government will identify better processes for communicating when an order is made under the *Criminal Justice (Mental Impairment) Act* or *Sentencing Act* to ensure that the MHT and members of the treating team know that an order has been made and what it provides for.

Resource-Related Response

The Government will consider any funding submissions in relation to this Review Outcome, through future Budget processes.

Appendix C Glossary of Terms

In this Document, the following terms are used:

- **"the Act"** means the *Mental Health Act 2013* (Tas)
- **"AMP"** means an Approved Medical Practitioner
- **"Approved Medical Practitioner"** means a person who has been approved under section 138 of the Act
- **"assessment"** is the clinical process involved in diagnosing the condition of a person's mental health and, where necessary, identifying the most appropriate treatment
- **"Assessment Order"** means an Assessment Order made under Division 1 of Part 3 of Chapter 2 of the Act
- **"Australian Lawyer"** means a person who is admitted to the legal profession under the *Legal Profession Act 2007* (Tas) or a corresponding law
- **"CCP"** means Chief Civil Psychiatrist
- **"CFP"** means Chief Forensic Psychiatrist
- **"Chief Civil Psychiatrist"** means the person for the time being holding or acting in the office referred to in section 143 of the Act
- **"Chief Forensic Psychiatrist"** means the person for the time being holding or acting in the office referred to in section 144 of the Act
- **"child"** means a person who is under 18 years of age
- **"controlling authority"** means the Secretary, for approved facilities run by or on behalf of the State. For any other approved facility, the controlling authority is the person who is in overall charge of the day-to-day clinical management of the facility at the relevant time
- **"decision-making capacity"** means a person's capacity to make a decision about his or her own assessment or treatment under the Act
- **"forensic patient"** means a person who has been admitted to the secure mental health unit under section 68 of the Act and who has not been discharged from the unit
- **"frisk search"**, of a patient, means a search that is conducted quickly by running the hands over the patient's outer clothing, or passing a metal detection device over or close to the patient's outer clothing, or examining anything worn or carried by the patient that he or she appears to have removed or discarded voluntarily, or passing a metal detention device over or close to anything the patient is wearing or carrying and that he or she appears to have removed or discarded voluntarily
- **"Interim Treatment Order"** means an Interim Treatment Order made under section 38 of the Act
- **"involuntary patient"** means a person who is subject to an Assessment Order, or to a Treatment Order
- **"legal practitioner"** means an Australian lawyer who holds a current practicing certificate, as defined in the *Legal Profession Act 2007* (Tas)
- **"medical practitioner"** means a person registered under the Health Practitioner Regulation National Law (Tasmania) in the medical profession

- **"Mental Health Officer"** means a person who has been approved as a Mental Health Officer under section139 of the Act
- **"Mental Health Tribunal"** means the Mental Health Tribunal established under section 167 of the Act
- **"mental illness"** has the meaning given to the term by section 4 of the Act
- **"MHO"** means a Mental Health Officer
- **"MHT"** means the Mental Health Tribunal
- **"Official Visitor"** means a person for the time being holding an appointment under subsection 155(2) of the Act
- **"ordinary search"** means a search of a patient that is limited to requiring the patient to remove any coat jacket or similar outer garment, hat, shoes, boots or like footwear, socks, gloves or mittens, handbag, backpacks or other carrying items, requiring the patient to empty all or any of his or her pockets, and examining the item or items removed and the contents of them and, if applicable, the contents of the pockets so emptied
- **"OV"** means Official Visitor
- **"parent"**, of a child, means a person having, for the child, all of the responsibilities which, by law, a parent has in relation to his or her children
- **"person with standing"** means a person listed in Clause 2 or Clause 3 of Part 2 of Schedule 4 of the Act
- **"POV"** means Principal Official Visitor
- **"President of the Tribunal"** means the person appointed to be the President of the Mental Health Tribunal
- **"Principal Official Visitor"** means the person for the time being holding an appointment under subsection 155(1) of the Act
- **"psychiatrist"** means a medical practitioner who:
    - is a Fellow of the RANZCP, or
    - holds specialist registration in the specialty of psychiatry, or
    - holds limited registration that enables the medical practitioner to practise the specialty of psychiatry
- **"representative"**, of a patient or prospective patient, means
    - the patient's guardian, or
    - the patient's Australian lawyer, or
    - if the patient is a child and raises no objection, a parent of the patient, or
    - any other person nominated by the patient to represent his or her interests.
- **"secure mental health unit"** means a secure mental health unit approved for the Act under section 140 of the Act
- **"supervision order"** means a supervision order made under the *Criminal Justice (Mental Impairment) Act 1999* (Tas) or *Sentencing Act 1997* (Tas)

- **"support person"**, of a patient or prospective patient, means a person who provides the patient with ongoing care or support
- **"this Report"** (or **the Report**) means the report on the outcome of the Review
- **"this Review"** (or **the Review**) means the Review that the Minister for Mental Health and Wellbeing is required to complete under section 229 of the Act, within six years after the commencement of the Act
- **"TLRI"** means the Tasmania Law Reform Institute
- **"treatment"** has the meaning given to the term by section 6 of the Act
- **"Treatment Order"** means a treatment order made under Division 2 of Part 3 of Chapter 2 and includes an Interim Treatment Order made under section 38, unless stated otherwise
- **"urgent circumstances treatment"** means treatment that is authorised under section 55 or section 87 of the Act
- **"voluntary inpatient"**, of an approved facility, means a person who has been admitted to the facility voluntarily to receive treatment for a mental illness and is receiving that treatment on the basis of informed consent.

Appendix D Governance Arrangements

Governance arrangements for the review featured:

- A Steering Committee comprised of:
    - Dr Aaron Groves, Chief Psychiatrist, Office of the Chief Psychiatrist, Mental Health, Alcohol and Drug Directorate.
    - Jeremy Harbottle, General Manager, Mental Health, Alcohol and Drug Directorate, Department of Health.
    - Kristy Bourne, Deputy Secretary Administration of Justice, Department of Justice.
    - Connie Digolis, Chief Executive Officer, Mental Health Council of Tasmania.
- A Statutory Reference Group comprised of Dr Groves, the Principal Official Visitor, the Public Guardian and the Commissioner for Children (or their nominees) and representatives from the Mental Health Tribunal, the Guardianship and Administration Board, the Tasmania Prison Service, Custodial Youth Justice, the Magistrates and Supreme Courts, the Legal Aid Commission of Tasmania, Tasmania Police and Ambulance Tasmania.
- A Clinical Reference Group comprised of Dr Groves and representatives from the Tasmanian Health Service, the RANZCP Tasmanian Branch, the ACMHN Tasmanian Branch, general practice and primary health.
- A Consumer Reference Group comprised of Dr Groves, the Senior Consumer and Carer Liaison Consultant from the Office of the Chief Psychiatrist, administrative and consumer representatives from Flourish Mental Health Action in Our Hands Inc., and representatives from Advocacy Tasmania.
- A Carer Reference Group comprised of Dr Groves, the Senior Consumer and Carer Liaison Consultant from the Office of the Chief Psychiatrist and administrative and consumer representatives from Mental Health Families and Friends Tasmania (formerly Mental Health Carers Tasmania) and Carers Tasmania.

Dr Groves was the Chair of the Steering Committee and of each of the Reference Groups.

Dr Groves was supported in these roles by staff situated in the Office of Chief Psychiatrist.

Appendix E Questions Asked

Chapter 4 The Act's Objects and Mental Health Service Delivery Principles	
4.1.1	**Question 1:** Are the Act's provisions being interpreted and applied in a way that promotes the Act's objects?
4.2.1	**Question 2:** Are people exercising responsibilities under the Act doing so in a way that has regard to the Mental Health Service Delivery Principles?
Chapter 5 Key Concepts	
5.1.1	**Question 3:** Is the test for decision-making capacity set out in section 7 of the Act operating effectively? Is it easy to understand and apply for both adults and children?
5.2.1	**Question 4:** Is the meaning of mental illness set out in section 4 of the Act operating as intended? Is it easy to understand and apply?
Chapter 6 Assessment Framework and Assessment Orders	
6.1.1	**Question 5:** Is the assessment framework established by the Act operating effectively? Is it easy to understand and apply?
6.2.1	**Question 11:** Are provisions of the Act relating to Assessment Orders operating effectively? Are they clear and easy to understand?
Chapter 7 Treatment Framework and Treatment Orders	
7.1.1	**Question 7:** Is the treatment framework established by the Act operating effectively? Is it easy to understand and apply?
7.2.1	**Question 12:** Are provisions of the Act relating to Treatment Orders operating effectively? Are they clear and easy to understand?
7.3.1	**Question 8:** Are the special psychiatric treatment provisions of the Act operating effectively? Are they easy to understand and apply?
Chapter 8 Assessment and Treatment for Children	
8.3.1	**Question 9:** Is the Act operating effectively to facilitate assessment and treatment for children? If not, why do you think this is?

Chapter 9 Involuntary Patient Transfers, Leave and Rights	
9.3.1	**Question 13:** Are provisions of the Act relating to involuntary patient transfers and leave operating effectively? Are they clear and easy to understand?
9.4.1	**Question 14:** Are involuntary patients being afforded the rights referred to in the Act and this document? If not, why do you think that is?
Chapter 10 Forensic Patients	
10.2.1	**Question 15:** Are provisions for the admission and detention of people to the secure mental health unit operating effectively?
10.3.1	**Question 16:** Are provisions for forensic patient movements and forensic patient leave operating effectively and efficiently? Are they clear and easy to understand?
10.5.1	**Question 18:** Are provisions for the management of forensic patients and the secure mental health unit operating effectively and efficiently? Are they clear and easy to understand?
10.6.1	**Question 19:** Are forensic patients being afforded the rights referred to in the Act and this document? If not, why do you think that is?
Chapter 10 Forensic Patients	
10.2.4	**Question 15:** Are provisions for the admission and detention of people to the secure mental health unit operating effectively?
10.3.8	**Question 16:** Are provisions for forensic patient movements and forensic patient leave operating effectively and efficiently? Are they clear and easy to understand?
10.4.2.2	**Question 17:** Are provisions for the treatment of forensic patients operating effectively and efficiently? Are they clear and easy to understand?
10.5.3	**Question 18:** Are provisions for the management of forensic patients and the secure mental health unit operating effectively and efficiently? Are they clear and easy to understand?
10.6.4	**Question 19:**

	Are forensic patients being afforded the rights referred to in the Act and this document? If not, why do you think that is?
Chapter 11 Seclusion and Restraint	
11.4.1	**Question 20:** Are the seclusion and restraint provisions of the Act operating effectively and efficiently?
Chapter 12 Protective Custody and Patient Escort	
12.3.4	**Question 10:** Are the protective custody and escort components of the Act operating effectively? Are they clear and easy to understand?
Chapter 13 Approved Facilities and Personnel	
13.2.1	**Question 21:** Are provisions for the approval and authorisation of facilities and people operating effectively and efficiently?
Chapter 14 Information Management	
14.2.1.3	**Question 22:** Are provisions of the Act for information management and record keeping operating effectively and efficiently?
Chapter 15 Mental Health Tribunal	
15.3.1	**Question 23:** Are provisions of the Act for the establishment, powers and functions of the Mental Health Tribunal operating effectively and efficiently?
15.5.1	**Question 24:** Are provisions of the Act for the Mental Health Tribunal's proceedings and determinations operating effectively and efficiently?
Chapter 16 Official Visitors	
16.4.1	**Question 25:** Are provisions of the Act for the appointment, powers and functions and other matters associated with Official Visitors operating effectively and efficiently??
Chapter 17 Chief Civil Psychiatrist and Chief Forensic Psychiatrist	
17.2.1	**Question 26:** Are provisions of the Act for the appointment, powers and functions and other matters associated with the Chief Psychiatrists operating effectively and efficiently?

	pursuing a national legislative scheme. Feedback on any aspect of these sections is nevertheless welcomed.
Chapter 18 Interstate Arrangements	
18.4.1	**Question 27:** Provisions of the Act for interstate agreements (sections 200 – 210) are not operational and it is not proposed to make any changes to the provisions until such time as Ministers have considered the issue and whether to commit to pursuing a national legislative scheme. Feedback on any aspect of these sections is nevertheless welcomed.
18.3	**Question 29:** Are provisions of the Act relating to offences and immunities operating effectively and efficiently?
18.4.4	**Question 30:** Are provisions of the Act relating to remote medical procedures, powers of sedation, conflicts of interest and the correction of orders operating effectively and efficiently?
18.4.4	**Question 31:** Are there any other aspects of the Act's operation that you would like to comment on?
Chapter 19 Other Matters	
19.1.1	**Question 28:** Is the Act operating as intended to maximise and promote consumer involvement in decision-making while facilitating the involvement of carers and family members to the extent that this is consistent with the consumer's wishes? If not, why do you think this is?
19.2.1	**Question 29:** Are provisions of the Act relating to offences and immunities operating effectively and efficiently?
19.3.1	**Question 30:** Are provisions of the Act relating to remote medical procedures, powers of sedation, conflicts of interest and the correction of orders operating effectively and efficiently?
19.4.1	**Question 31:** Are there any other aspects of the Act's operation that you would like to comment on?

Appendix F Representative Bodies or Groups

Body or Group	Contact Details	
Flourish Mental Health Action In Our Hands Inc	Write	Po Box 4836 Bathurst Street Post Office HOBART TAS 7000
	Call	03 6223 1952
	Email	ivanz@flourishtas.org.au
Advocacy Tasmania	Call	1800 005 131
	Email	advocacy@advocacytasmania.org.au
Mental Health Families and Friends Tasmania Inc. (formerly known as Mental Health Carers Tasmania)	Write	2 Terry Street GLENORCHY TAS 7010
	Call	03 6228 7448
	Email	admin@mentalhealthcarerstas.org.au
Carers Tasmania	Write	64 Burnett Street NORTH HOBART TAS 7000
	Call	03 6144 3700
	Email	peak@carerstasmania.org
RANZCP Tasmanian Branch	Write	GPO Box 1236 HOBART TAS 7001
	Call	03 6270 2260
	Email	christine.walker@ranzcp.org
ACMHN Tasmanian Branch	Write	GPO Box 125 HOBART TAS 7001
	Call	0418 697 574
	Email	cecily.pollard@ths.tas.gov.au

Appendix G Mental Health Service Delivery Principles

The mental health service delivery principles are as follows:

(a) to respect, observe and promote the inherent rights, liberty, dignity, autonomy and self-respect of persons with mental illness

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

(c) to provide a service that is comprehensive, accessible, inclusive, equitable and free from stigma

(d) to be sensitive and responsive to individual needs (whether as to culture, language, age, religion, gender or other factors)

(e) to emphasise and value promotion, prevention and early detection and intervention

(f) to seek to bring about the best therapeutic outcomes and promote patient recovery

(g) to provide services that are consistent with patient treatment plans

(h) to recognise the difficulty, importance and value of the role played by families, and support persons, of persons with mental illness

(i) to recognise, observe and promote the rights, welfare and safety of the children and other dependants of persons with mental illness

(j) to promote the ability of persons with mental illness to make their own choices

(k) to involve persons receiving services, and where appropriate their families and support persons, in decision-making

(l) to recognise families, and support persons, of persons with mental illness as partners, with mental health service providers, in the provision of their treatment and care to the extent that this is appropriate and consistent with their own wishes

(m) to respect the wishes of persons receiving services, and the wishes of their families and support persons, to the maximum extent consistent with the health and safety of those persons and the safety of others

(n) to promote and enable persons with mental illness to live, work and participate in their own community

(o) to operate so as to raise community awareness and understanding of mental illness and to foster community-wide respect for the inherent rights, liberty, dignity, autonomy and self-respect of persons with mental illness

(p) to be accountable

(q) to recognise and be responsive to national and international clinical, technical and human rights trends, developments and advances.

Appendix H Meaning of Mental Illness

For the purposes of this Act:

(a) a person is taken to have a mental illness if he or she experiences, temporarily, repeatedly or continually –

(i) a serious impairment of thought (which may include delusions); or

(ii) a serious impairment of mood, volition, perception or cognition; and

(b) nothing prevents the serious or permanent physiological, biochemical or psychological effects of alcohol use or drug-taking from being regarded as an indication that a person has a mental illness.

(2) However, under this Act, a person is not to be taken to have a mental illness by reason only of the person's –

(a) current or past expression of, or failure or refusal to express, a particular political opinion or belief; or

(b) current or past expression of, or failure or refusal to express, a particular religious opinion or belief; or

(c) current or past expression of, or failure or refusal to express, a particular philosophy; or

(d) current or past expression of, or failure or refusal to express, a particular sexual preference or orientation; or

(e) current or past engagement in, or failure or refusal to engage in, a particular political or religious activity; or

(f) current or past engagement in a particular sexual activity or sexual promiscuity; or

(g) current or past engagement in illegal conduct; or

(h) current or past engagement in an antisocial activity; or

(i) particular economic or social status; or

(j) membership of a particular cultural or racial group; or

(k) intoxication (however induced); or

(l) intellectual or physical disability; or

(m) acquired brain injury; or

(n) dementia; or

(o) temporary unconsciousness.

Appendix I Involuntary Patient Rights

The Act requires an involuntary patient to be given a Statement of Rights in the following circumstances:

- A person in protective custody who has been escorted to an approved assessment centre under section 18 of the Act is required to be given a Statement of Rights in a form approved by the CCP as soon as practicable after his or her arrival at the approved assessment centre. This requirement is set out in section 19 of the Act.
- An MHO or police officer who releases a person from protective custody is to give the person a copy of a record of matters related to the custody. This requirement is set out in section 21 of the Act.
- A medical practitioner who makes an Assessment Order for a person is required to give the person copy of the Order and a Statement of Rights in a form approved by the CCP as soon as practicable after the Order is made. This requirement is set out in section 29 of the Act.
- An AMP who affirms an Assessment Order is to give notice of this, and of any extension of the operation of the Order, to the patient. This requirement is set out in section 33 of the Act.
- An AMP who applies for a Treatment Order to be made or renewed is required to give the person in respect of whom the Order is sought a copy of the application, and a Statement of Rights in a form approved by the President of the Tribunal. These requirements are set out in sections 37 and 48 of the Act.
- The MHT is required to give a patient in respect of whom a Treatment Order has been made or renewed notice to this effect, and a copy of the Order, along with a Statement of Rights in a form approved by the President of the Tribunal. These requirements are set out in sections 45 and 48 of the Act.
- A medical practitioner who prepares or varies a treatment plan is required to give a copy of the plan and notice of (and reasons for) the variation to the patient. These requirements are set out in sections 53 and 54 of the Act.
- An AMP who authorises urgent circumstances treatment for an involuntary patient is required to tell the patient about the authorisation and to give a copy of the authorisation to the patient, along with a Statement of Rights in a form approved by the CCP. This requirement is set out in section 55 of the Act.
- A person who authorises seclusion or restraint is to give a copy of relevant records to the patient who has been secluded or restrained, along with a Statement of Rights in a form approved by the CCP. This requirement is set out in section 58 of the Act.
- The CCP or a delegate is required to give a copy of documentation relating to the patient's transfer from one approved hospital to another to the patient being transferred, along with a Statemen of Rights in a form approved by the CCP. This requirement is set out in section 59 of the Act.
- An AMP who approves, or who refuses to approve, leave for an involuntary patient is required to give a copy of the leave pass or notice of refusal to the patient, along with a Statement of Rights in a form approved by the CCP. Notice of an extension, variation or cancellation of leave is also to be given. These requirements are set out in section 60 of the Act.
- On authorising the admission of an involuntary patient to a secure mental health unit, or extending the period of admission, the CFP or delegate is to give notice of the admission (or extension), the reasons for the admission (or extension) and the period of detention (as extended if relevant) to the

patient, along with a Statement of Rights relating to the patient's rights as a forensic patient in a form approved by the CFP. This requirement is set out in section 64 of the Act.

- On authorising special psychiatric treatment, the MHT is to ensure that a copy of the authorisation is given to the patient before the treatment starts, together with a Statement of Rights in a form approved by the CCP. This requirement is set out in section 127 of the Act.
- The controlling authority of an approved hospital or approved assessment centre (or their delegate) is required to give a person a Statement of Rights in a form approved by the CCP whenever the person is admitted to the facility as a patient, and whenever the patient is discharged from the facility. This requirement is set out in section 129 of the Act.
- A mental health authority that withholds, defers the giving or qualifies information that is given to a patient or any private person about a patient in respect of any matter under the Act is required to give notice of the withholding, deferral or qualification, with reasons, to the patient. This requirement is set out in section 132 of the Act.
- On reviewing an Assessment Order, the MHT is required to give a copy of its determination to the patient along with a Statement of Rights in a form approved by the President of the Tribunal. This requirement is set out in section 180 of the Act.
- Within 24 hours of varying a Treatment Order, the MHT is required to give a copy of its determination to the patient, along with a Statement of Rights in a form approved by the President of the Tribunal. This requirement is set out in section 181 of the Act.
- Within 24 hours of correcting an order, determination, direction or other document under section 224A, the MHT must give a copy of the corrected document to the patient along with a Statement of Rights in a form approved by the President of the Tribunal.

Under section 62, every involuntary patient has the following rights:

- the right to have the restrictions on, and interference with, his or her dignity, rights and freedoms kept to a minimum consistent with his or her health or safety and the safety of other persons
- the right to have his or her decision-making capacity promoted, and his or her wishes respected, to the maximum extent consistent with his or her health or safety and the safety of other people
- the right, while in an approved hospital, to have access to current information about local, national and world events
- the right to be given clear, accurate and timely information about:
    - his or her rights as an involuntary patient
    - the rules and conditions governing his or her conduct in the hospital
    - his or her diagnosis and treatment
- the right, while in an approved hospital, to apply for leave of absence in accordance with the Act
- the right to have contact with, and to correspond privately with, his or her representatives and support persons and with Official Visitors
- the right, while in an approved hospital, to be provided with general health care
- the right, while in an approved hospital, to wear his or her own clothing (where appropriate to the treatment setting)

- the right, while in an approved hospital, not to be unreasonably deprived of any necessary physical aids
- the right, while in an approved hospital, not to be unreasonably deprived of any communication aid
- the right, while in an approved hospital, to be detained in a manner befitting his or her assessment, treatment or care requirements
- the right, while in an approved hospital, to practise a religion of the patient's choice, to join with other patients in practising that religion and to possess such articles as are reasonably necessary for the practice of that religion (to such extent as is consistent with his or her health or safety, the safety of other persons and the management, good order and security of the hospital)
- the right, while in an approved hospital:
    - to practise customs in accordance with the patient's cultural beliefs or cultural background, and
    - to join with other patients in practising those customs, and
    - to possess articles that are reasonably necessary for the practice of those customs

  to the extent that the practice of those customs is not contrary to any law and is consistent with the health and safety of the patient and other patients and the management, good order and security of the hospital
- the right, while in an approved hospital, to ask for and be given such reasonable help from hospital staff as will enable the patient to enjoy these rights.

Appendix J Forensic Patient Rights

The Act requires a forensic patient to be given a Statement of Rights in the following circumstances:

- On refusing a request from a forensic patient who is a prisoner or youth detainee to return to prison or youth detention, the CFP (or delegate) is to give notice of the refusal, along with a Statement of Rights in a form approved by the CFP. The requirement to do this is set out in section 70 of the Act.
- On transferring a forensic patient from a secure mental health unit to a secure institution, approved hospital or other premises, the CFP (or delegate) is to give a copy of the transfer direction to the patient, along with a Statement of Rights in a form approved by the CFP. The requirement to do this is set out in section 73 of the Act.
- On granting or refusing leave to a forensic patient who is subject to a restriction order, the MHT is to give the patient a copy of a record of the matter, along with a Statement of Rights in a form approved by the President of the Tribunal. The patient is also to be given other documentation associated with aspects of any leave that has been granted. The requirement to do this is set out in sections 78 and 79 of the Act.
- On granting or refusing leave to a forensic patient who is not subject to a restriction order, the CFP or treating medical practitioner is to give the patient a copy of a record of the matter, along with a Statement of Rights in a form approved by the CFP. The patient is also to be given other documentation associated with aspects of any leave that has been granted. The requirement to do this is set out in sections 82 and 83 of the Act.
- An AMP who authorises urgent circumstances treatment for a forensic patient is required to ensure that the patient is told of the authorisation as soon as possible after it is given and to give a copy of the authorisation to the patient, along with a Statemen of Rights in a form approved by the CFP. The requirement to do this is set out in section 87 of the Act.
- The MHT is required to give a copy of any authorisation of treatment for a forensic patient to the patient, along with a Statement of Rights in a form that has been approved by the President of the Tribunal. The requirement to do this is set out in sections 88 and 91 of the Act.
- The controlling authority of a secure mental health unit is required to make a record of the use of force, or seclusion or restraint of a forensic patient and to give a copy of the record to the patient, together with a Statement of Reasons in a form that has been approved by the CFP. The requirement to do this is set out in section 96 of the Act.
- On authorising special psychiatric treatment for a forensic patient, the MHT is to ensure that a copy of the authorisation is given to the patient before the treatment starts, together with a Statement of Rights in a form approved by the CFP. This requirement is set out in section 127 of the Act.
- The controlling authority of a secure mental health unit (or their delegate) is required to give a person a Statement of Rights in a form approved by the CFP whenever the person is admitted to the facility as a patient, and whenever the patient is discharged from the facility. This requirement is set out in section 129 of the Act.
- A mental health authority that withholds, defers the giving or qualifies information that is given to a patient or any private person about a patient in respect of any matter under the Act is required to give notice of the withholding, deferral or qualification, with reasons, to the patient. This requirement is set out in section 132 of the Act.

- Within 24 hours of reviewing an authorisation of treatment for a forensic patient, the MHT is to give a copy of its determination to the patient, along with a Statement of Rights in a form approved by the President of the Tribunal. The requirement to do this is set out in section 192 of the Act.
- Within 24 hours of correcting an order, determination, direction or other document under section 224A, the MHT must give a copy of the corrected document to the patient along with a Statement of Rights in a form approved by the President of the Tribunal.

The further rights that forensic patients have are set out in section 108 and include:

- the right to have the restrictions on, and interference with, his or her dignity, rights and freedoms, kept to a minimum consistent with his or her health or safety and the safety of other people
- the right to have his or her decision-making capacity promoted, and his or her wishes respected, to the maximum extent consistent with his or her health or safety and the safety of other persons
- the right, while in a secure mental health unit, to have access to current information about local, national and world events
- the right to be given clear, accurate and timely information about:
    - his or her rights as a forensic patient
    - the rules and conditions governing his or her conduct in the secure mental health unit
    - his or her diagnosis and treatment
- the right, while in an SMHU, to apply for leave of absence in accordance with the Act
- the right to be provided with general health care
- the right to be provided with food that is adequate to maintain the patient's health and wellbeing and with a varied diet
- the right to be provided with special dietary food if the CFP is satisfied that such food is necessary for medical reasons, because of the patient's religious beliefs or because the patient is a vegetarian
- the right to be provided with basic clean clothing that is suitable for the climate, of suitable size and adequate to maintain the health of the patient
- the right to wear suitable clothing that the patient owns
- the right not to be unreasonably deprived of any necessary physical aids or communication aids
- the right to adequate toilet and sanitary arrangements
- the right to adequate light and air
- the right to practise a religion of the patient's choice and, if consistent with the management, good order and security of the secure mental health unit, to join with other forensic patients in practising that religion and to possess such articles as are reasonably necessary for the practice of that religion
- the right:
    - to practise customs in accordance with the patient's cultural beliefs or cultural background
    - to join with other patients in practising those customs
    - to possess articles that are reasonably necessary for the practice of those customs,

to the extent that the practice of those customs is not contrary to any law and is consistent with the health and safety of the patient and other patients and the management, good order and security of any approved facility that the person is in

- the right to have access to legal advice
- the right to be provided with information about the rules and conditions which will govern the patient's behaviour in the secure mental health unit
- the right, while in the secure mental health unit, to ask for and be given the help that the patient needs to enable him or her to enjoy these rights.

Appendix K Record Keeping Requirements

The Act imposes the following record keeping requirements:

- An MHO or police officer who takes a person into protective custody is to make a record of the matter. An MHO or police officer who releases a person from protective custody is to make a record of the matter and provide a copy of that record, along with the record made when the person was taken into protective custody, to the person and to the CCP. These requirements are set out in section 21 of the Act.
- A medical practitioner who examines a person in protective custody is to make a record of the matter, place a copy of the record on the person's clinical file and give the CCP a copy of the record. This requirement is set out in section 21 of the Act.
- A medical practitioner who makes an Assessment Order must document relevant matters using a CCP Approved Form. He or she must then give a copy of the Order to the patient, to the AMP who is likely to independently asses the patient or the controlling authority of the patient where the patient is, or is likely to be, assessed, and place a copy of the Order on the patient's clinical record. These requirements are set out in sections 26 and 29 of the Act.
- An AMP who affirms an Assessment Order is required to give notice of the affirmation to the patient, the medical practitioner who made the Order, the CCP, the MHT, and the controlling authority of any approved facility that the patient is in, or is likely to be in. The AMP is also required to place a copy of the Instrument of Affirmation on the patient's clinical record. These requirements are set out in section 33 of the Act.
- A medical practitioner who discharges an Assessment Order is required to complete a Discharge Paper, to give a copy of the discharge paper to the patient, the CCP, the MHT, and the AMP who was expected to do the assessment or the controlling authority of the approved facility where the assessment was to be done. The medical practitioner is also required to place a copy of the Discharge Paper on the patient's clinical record. These obligations are set out in section 35 of the Act.
- An AMP who applies for a Treatment Order is required to complete an application. The application is required to be accompanied by a statement by the applicant affirming that (and explaining how) the person meets the treatment criteria and an indication of whether an Interim Treatment Order is needed. The applicant is also required to provide a copy of any Assessment Order to which the person is subject, to give a copy of the application to the person and to place a copy of the application on the person's clinical record. These requirements are set out in section 37 of the Act.
- On making a Treatment Order, the MHT is required to give the patient notice of this and a copy of the Order. The MHT is also required to give notice that the Order has been made, and a copy of the Order to the AMP who applied for the Order, the treating medical practitioner, the controlling authority of any approved facility that the patient is in or is expected to be in, and the CCP. These requirements are set out in section 45 of the Act.
- An AMP who applies for the renewal of a Treatment Order is required to complete an application. The application is required to be accompanied by a copy of the Treatment Order, details of any recommended change in treatment or to the treatment setting, and a statement by the applicant affirming that (and explaining how) the patient continues to meet the treatment criteria and is expected to continue to meet those criteria for the period of renewal. The applicant is also required to give a copy of the application to the patient, the treating medical practitioner (if this is not the applicant), the CCP and the controlling authority of any approved facility that the patient is in, or is

expected to be in. Lastly the applicant is required to place a copy of the application and accompanying documentation on the patient's clinical record. These obligations are set out in section 48 of the Act.

- On renewing a Treatment Order the MHT is required to give notice of the renewal to the patient, the applicant, the treating medical practitioner (if this is someone other than the applicant), the controlling authority of any approved facility that the patient is in (or is expected to be in) and the CCP. These obligations are also set out in section 48 of the Act.
- An AMP who discharges a Treatment Order is to complete a Discharge Paper and provide a copy of the Discharge Paper to the patient, the treating medical practitioner (if this is someone other than the AMP), the CCP and the MHT. He or she is also required to place a copy of the Discharge Paper on the patient's clinical records. These obligations are set out in section 49 of the Act.
- A medical practitioner who prepares or varies a treatment plan is required to give a copy of the plan or details of the variation (and the reasons for any variation) to the patient and to the CCP, and to place a copy of the plan on the patient's clinical record. These requirements are set out in sections 53 and 54 of the Act.
- An AMP who authorises urgent circumstances treatment for a patient is required to ensure the patient is advised of the authorisation as soon as possible after it is given and to give a copy of the authorisation to the relevant Chief Psychiatrist, the MHT and the patient and to place a copy of the authorisation on the patient's clinical record. The requirement to do this for involuntary patients is set out in section 55 of the Act. The requirement to do this for forensic patients is set out in section 87 of the Act.
- A person who authorises seclusion or restraint is to make a record of the matter and give a copy of the record to the patient, the CCP and the MHT. A copy is also required to be placed on the patient's clinical record. The requirement to do this for involuntary patients is set out in section 58 of the Act. The requirement to do this for forensic patients is set out in section 96 of the Act.
- The CCP or a delegate may direct an involuntary patient's transfer from one approved hospital to another. A copy of the transfer direction is to be given to the patient, the controlling authority of each approved hospital, the treating medical practitioner and the MHT. A copy of the transfer direction is also to be placed on the patient's clinical record. These obligations are set out in section 59 of the Act.
- An AMP who grants an involuntary patient leave is to document the leave in a leave pass and give a copy of the leave pass to the patient, the controlling authority of the relevant approved hospital, the patient's escort (if applicable), the MHT and the CCP. The AMP is also required to place a copy of the leave pass on the patient's clinical record. Any extension, variation or cancellation of the leave is to be similarly documented. These obligations are set out in section 60 of the Act.
- An AMP who refuses an application for leave for an involuntary patient is required to give notice of the refusal, with reasons, to the applicant and the patient, if the applicant was someone other than the patient. The AMP is also required to place a copy of the notice of refusal on the patient's clinical records. These obligations are set out in section 60 of the Act.
- A patient's treating medical practitioner is required to alert the MHT if an involuntary patient has taken leave from an approved hospital and the patient fails to comply with a condition of leave, or the leave is cancelled or if a period of leave that has been granted to the patient has expired and the patient has not returned to the approved hospital. These obligations also apply if a patient is absent without leave from an approved hospital. In these scenarios the patient's treating medical

practitioner may also alert the Commissioner of Police of the circumstances. These obligations are set out in section 61 of the Act.

- On authorising the admission of an involuntary patient to a secure mental health unit, the CFP (or delegate) is to give notice of the admission, the reasons for the admission and the period of detention to the patient. The CFP (or delegate) is also required to give notice of the admission and the period of detention to the controlling authority of the secure mental health unit, the controlling authority of the approved hospital from which the patient is being transferred, the CCP and the MHT. Similar obligations apply to any decision by the CFP (or delegate) to extend the period of detention. These requirements are set out in section 64 of the Act.
- On accepting or refusing to accept a request from a forensic patient who is a prisoner or youth detainee to return to prison or youth detention, the CFP (or delegate) is required to make and keep a record of the request and the CFP's decision. On refusing a request the CFP (or delegate) is also required to give notice of the refusal to the patient and the MHT. These obligations are set out in section 70 of the Act.
- On directing that a forensic patient be removed from a secure mental health unit and transferred to a secure institution, approved hospital or other premises, the CFP (or delegate) is required to complete a transfer direction. The CFP or delegate is required to give a copy of the transfer direction to the patient, the controlling authority of the secure mental health unit, the person in charge of the secure institution, approved hospital, health service or other place to which the patient is transferred, the treating medical practitioner and the MHT. The CFP or delegate is also required to place a copy of the transfer direction on the patient's clinical record. These obligations are set out in section 73 of the Act.
- A person who applies for leave of absence for a forensic patient who is subject to a restriction order from an approved hospital is required to apply using an MHT form for this purpose. The CFP may determine the period of leave in the case of leave that has been granted for a particular purpose without a period being specified and in this case the CFP is required to make a record of the matter and give a copy of the record to the MHT, the patient and a range of other people, and to place a copy of the record on the patient's clinical record. The MHT is also required to make a record of leave that is granted or refused, and to give a copy of the record to the patient and other relevant people. These obligations are set out in section 78 of the Act.
- In the case of leave for a forensic patient who is not subject to a restriction order, the treating medical practitioner may determine the period of leave in the case of leave that has been granted for a particular purpose without a period being specified and in this case the treating medical practitioner is required to make a record of the matter and to give a copy of the record to the patient and a range of other people, and to place a copy of the record on the patient's clinical record. The CFP or delegate is also required to make a record of leave that is granted or refused, and to give a copy of the record to the patient and other relevant people. These obligations are set out in section 82 of the Act.
- On cancelling leave that has been granted to a forensic patient, the person who has cancelled the leave is required to make a record of the cancellation and give a copy of the record to a range of people including the MHT (if the patient is subject to a restriction order) and the CFP (if the patient is not subject to a restriction order) and to place a copy of the record on the patient's clinical file. These obligations are set out in sections 79 and 83 of the Act.
- On applying to the MHT for authorisation of treatment for a forensic patient, an AMP must complete a written form. On authorising treatment for a forensic patient, the MHT is to document the authorisation and give a copy of the authorisation (or advice that authorisation has been given, in the

case of an interim Treatment Order) to the patient, the applicant and the CFP. These requirements are set out in sections 88 and 91 of the Act.

- The controlling authority is to make a record of the application of force to a forensic patient and give a copy of the record to the patient, the CFP and the MHT, and to place a copy of the record on the patient's clinical record. The requirement to do this is set out in section 96 of the Act.
- On authorising a search, the CFP or controlling authority is required to document the authorisation. The requirement to do this is set out in section 111.
- On authorising special psychiatric treatment, the MHT is required to ensure that the authorisation contains certain information and that a copy of the authorisation is given to the patient and to the relevant Chief Psychiatrist. The requirement to this is set out in section 127 of the Act.
- On giving a patient special psychiatric treatment, a treating medical practitioner is to make a record of the matter, place a copy of the record on the patient's clinical record and give a copy of the record to the relevant Chief Psychiatrist and the MHT. The requirement to do this is set out in section 128 of the Act.
- On withholding, deferring or qualifying information, a mental health authority is to make a note about the withholding, deferral or qualification on the patient's clinical record, and give notice of the withholding, deferral or qualification of the information, with good reasons, to the patient, the patient's representative and the MHT and the relevant Chief Psychiatrist, if the mental health authority is not the Chief Psychiatrist. The requirement to do this is set out in section 132 of the Act.
- On reviewing an Assessment Order, the MHT is to give a copy of its determination to the patient, the CCP and the controlling authority (if the Order is still in effect and requires the patient's admission to an approved facility). The requirement to do this is set out in section 180 of the Act.
- On varying a Treatment Order, the MHT is to give a copy of its determination to the patient, the controlling authority of an approved hospital (if the Order has required or will require the patient's admission to an approved hospital), the CFP and the controlling authority of the relevant secure mental health unit (if the patient is also a forensic patient), and in any other case, the CCP. The requirement to do this is set out in section 181 of the Act.
- On reviewing the authorisation of treatment for a forensic patient, the MHT is to give a copy of its determination to the patient, the controlling authority of the relevant secure mental health unit and the CFP. The requirement to do this is set out in section 192 of the Act.
- On sedating a patient who is being transported by ambulance under the Act, an approved MHO or approved medical officer is required to give the CCP a report of the matter. The report is to be in an approved form and to include the matters referred to in section 212.
- On correcting an order, determination, direction or other document, the MHT must give a copy of the corrected document to the patient, the controlling authority of an approved hospital (if the patient has been, is or will be admitted to, or detained in, an approved hospital), the CFP and controlling authority of the relevant secure mental health unit (if the patient is a forensic patient), and in any other case, the CCP. The requirement to do this is set out in section 224 of the Act.
- The MHT is to ensure that a party to any MHT proceedings is given reasonable notice of each hearing held in the course of those proceedings. The MHT may also notify other people as it thinks fit in the circumstances. The requirement to do this is set out in Schedule 4 Part 2 of the Act.

- The MHT is required to make and keep a record of each of its proceedings. The obligation to do this is set out in Schedule 4 Part 2 of the Act.
- The MHT is required to provide parties to proceedings with a statement of reasons for making any determination in or in respect of those proceedings on application of a party to the proceedings. The requirement for the MHT to do this is set out in Schedule 4 Part 6 of the Act.

Appendix L Mental Health Tribunal Review Functions

The MHT's review functions are as follows:

- Section 180 relates to the review of Assessment Orders. Under that section, the MHT may review the making of an Assessment Order at any time on its own motion or on the application of any person with the necessary standing.
- Section 181 relates to the review of Treatment Orders. Under that section, the MHT must review a Treatment Order within 60 days, within180 days, and at subsequent 180-day intervals, after the Order is made if it is still in effect at the relevant time, and within three days of being notified that a patient who is subject to a Treatment Order has been admitted to an approved hospital for failure to comply with the Order. The section also confirms the MHT's capacity to review an Order at any other time on its own motion or on the application of a person with the necessary standing, and to vary a Treatment Order at any time on its own motion, on the application of any AMP, or on the application of any person with the necessary standing.
- Section 182 relates to the review of the admission of an involuntary patient to a secure mental health unit. The section requires the MHT to review a patient's admission, and any extension of the admission, within three days of being notified. As with other review, the MHT may also review the admission or extension at any other time on the MHT's own motion or on the application of any person with the necessary standing.
- Section 183 relates to the review of a decision by the CFP to refuse to allow a prisoner or youth detainee who has been detained in the secure mental health unit on the prisoner or detainee's own request to return to prison or youth detention. Under the section, the MHT may review the refusal on its own motion or on the application of any person with the necessary standing, and a review conducted on the application of any person with the necessary standing must occur within 7 days.
- Section 184 relates to the review of the status of voluntary inpatients. Section 184 requires the MHT to review a patient's status once he or she has been a voluntary inpatient for a period of six months continuously, with the review commencing within 30 days of the six-month period passing and at six monthly intervals thereafter for so long as the person remains a voluntary inpatient. The MHT may additionally review the patient's status at any other time on the MHT's own motion or on the request of any person with the necessary standing.
- Section 185 relates to the review of the admission of prisoners or youth detainees to the secure mental health unit. The section requires the MHT to review an admission of this kind within seven days of being notified of the admission. The MHT may also review an admission at any other time on the MHT's own motion or on the application of any person with the necessary standing.
- Section 186 relates to the review of urgent circumstances treatment. Under the section, the MHT may conduct a review at any time on its own motion or on the application of any person with the necessary standing, even if the treatment has ended. Actions available to the MHT following a review include recommending that a patient be examined against the treatment criteria to see if a Treatment Order needs to be made and in the case of a forensic patient, recommending that an AMP seek the MHT's authorisation of treatment in respect of the patient.
- Section 187 relates to the review of seclusion and restraint. Under the section, the MHT is required to do a review on the application of any person with the necessary standing and may do so on its own motion at any time, even if the seclusion has ended.

- Section 188 relates to the application of force to a forensic patient. As with seclusion and restraint, the section requires the MHT do to a review on the application of any person with the necessary standing and may do so on its own motion at any time, even if the application of force has ended.
- Section 189 governs review by the MHT of the withholding of information from a patient. Under the section, the MHT is required to conduct a review on the application of any person with the necessary standing and may do so on its own motion at any time.
- Section 190 governs review by the MHT of involuntary and forensic patient transfer within Tasmania. The section requires the MHT to conduct a review on the application of any person with the necessary and enables the MHT to conduct a review on its own motion at any other time.
- Section 191 governs the review of matters relating to patient leave. As with other sections, section 191 requires the MHT to do a review on the application of any person with the necessary standing and provides the MHT with discretion to conduct a review on its own motion at any other time, regardless of whether the leave is prospective, has commenced or concluded, or has been varied.
- Section 192 applies to the review of forensic patient visiting, telephone and correspondence rights. The MHT is required to conduct a review on the application of a person with the necessary standing and may do a review on its own motion at any other time, regardless of whether the relevant rights have been exercised.
- Section 192A applies to the review of the authorisation of treatment for forensic patients. Under the section, the MHT must review an authorisation within 60 days and 180 days after it is made, and at 180-day intervals thereafter, if the authorisation is still in effect at that time. The MHT may also review an authorisation at any other time on its own motion or on the application of any person with the necessary standing.
- Section 193 governs the review of any decision or matter that is not explicitly covered by the Act. The MHT may do reviews of this kind on its own motion at any time or on the application of the person with the necessary standing.

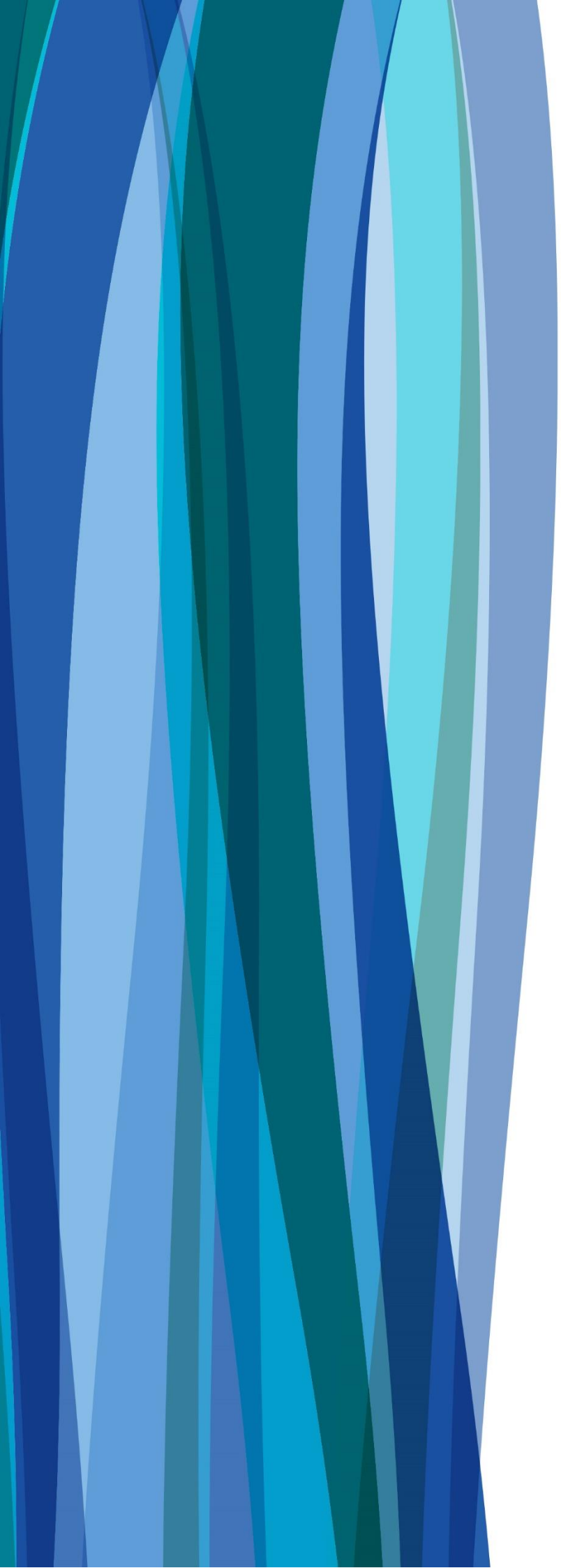
Appendix M Chief Psychiatrist Approved Forms

The CCP has approved forms for the following matters:

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

The CFP has approved forms for the following matters:

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



Tasmanian Government

Office of the Chief Psychiatrist
Department of Health

GPO Box 125
Hobart TAS 7001

03 6166 0778

chief.psychiatrist@health.tas.gov.au

www.health.tas.gov.au