Statewide and Mental Health Services

Mental Health Bill 2011

Exposure Draft

June 2011

Explanatory Guide

Department of Health and Human Services

Tasmania
Explore the possibilities

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Introduction

The exposure draft of the *Mental Health Bill 2011* was released for public comment on 27 June 2011.

The purpose of this document is to explain the Bill's key features to assist individuals and groups who wish to provide feedback on the draft Bill and its provisions. It is not intended to be an exhaustive guide to the draft Bill.

All feedback received will be carefully considered at the end of the public consultation period and the draft Bill will be amended as necessary. The Bill will then be finalised and introduced to Tasmanian Parliament. It is likely that this will occur towards the end of 2011.

It is envisaged that the new legislation will be implemented over a period of at least six months.

How to access the draft exposure Bill and this document

The draft exposure *Mental Health Bill 2011* and copies of this document can be accessed online from the Department of Health and Human Services website www.dhhs.tas.gov.au/mentalhealth

Requests for hard copies may also be made by contacting:

New Mental Health Act
Statewide and Mental Health Services
Department of Health and Human Services
GPO Box 125
HOBART TAS 7001
Email: mhact@dhhs.tas.gov.au
Tel: 03 6230 7929
Fax: 03 6233 7939

How to Provide Feedback

The draft Bill has been developed to reflect the issues and concerns raised by stakeholders in response to the *Mental Health Act 1996* Review Issues and Discussion Papers.

The purpose of this consultation process is to seek the views of stakeholders about whether or not the draft exposure Bill appropriately achieves what it sets out to achieve, and addresses the issues raised throughout previous consultation processes.

Feedback on any and all aspects of the draft Bill is invited, including:

- How the new legislation will work in practice
- How the provisions will impact on consumers, support persons including family members and carers and health care professionals
- Whether the involuntary assessment and treatment criteria are appropriate
- Whether the review and oversight mechanisms outlined in the Bill are sufficient
- Whether the Bill regulates matters that it shouldn't
- Whether the Bill fails to regulate matters that it should

The closing date for feedback is **Monday, 8 August 2011**.

Written Feedback

Written submissions can either be emailed to mhact@dhhs.tas.gov.au or posted to:

New Mental Health Act
Statewide and Mental Health Services
Department of Health and Human Services
GPO Box 125
HOBART TAS 7001

Feedback can also be provided online. A form for this purpose can be accessed at www.dhhs.tas.gov.au/mentalhealth

Verbal Feedback

Verbal feedback can be provided by telephoning 03 6230 7929

Feedback in Person

Community forums will be held in the North, North West and South of the State, as follows:

Launceston
Date: Tuesday, 19 July 2011
Time: 5.30 pm – 7.00 pm
Venue: Mercure Hotel, Earl Street, Launceston

Ulverstone
Date: Wednesday, 20 July 2011
Time: 5.30 pm – 7.00 pm
Venue: Bass and Flinders Motor Inn, 49 – 51 Eastlands Drive, Ulverstone

Hobart
Date: Tuesday, 26 July 2011
Time: 5.30 pm – 7.30 pm
Venue: Mercure Hotel, 156 Bathurst Street, Hobart

Stakeholders can express their interest in attending by emailing mhact@dhhs.tas.gov.au or telephoning 03 6230 7929.

Confidentiality

All written submissions received in response to the draft Bill will be treated as public information unless a request otherwise is made. This means that your name, submission or comments from your submission may be placed on the Department of Health and Human Services website. Your submission or parts from it may also be quoted and you may be directly or indirectly identified as the author of the submission.

If you wish any element of your submission, or your name to remain confidential please indicate this clearly in the body of the submission.

Background

The current *Mental Health Act 1996* was introduced in 1996. The current Act was drafted to reflect modern approaches to the care of people with mental illness, and followed nearly 10 years of extensive community consultation. The primary intention of the Act was to bring Tasmanian legislation into line with national and international principles and standards in mental health of the time, including the *National Mental Health Policy and Plan*, *United Nations Principles on the Care and Protection of People with a Mental Illness and for the Improvement of Mental Health Care*, the *National Statement of Rights and Responsibilities* and the *National Model Mental Health Legislation*.

Parts 10A (sections 72A – 74O), 10B (sections 73T – 74O) and Schedule 1A were introduced to the current Act in 2005 to accommodate the establishment of Tasmania's secure mental health unit, the Wilfred Lopes Centre, and to facilitate the Centre's operation. That year also saw the introduction of provisions (sections 44A – C) regulating the enforcement of Community Treatment Orders.

A review of the current Act formally commenced in October 2006. At that time the scope of the review was limited to considering the following matters:

- The introduction of involuntary treatment provisions to the Act
- The enforceability of Community Treatment Orders
- The Act's capacity to support ongoing improvements to the delivery of mental health services in Tasmania consistent with the *Mental Health Services Strategic Plan 2006-2011*.

An Issues Paper canvassing these matters was released in April 2007 for a six week consultation period. Feedback received in response to the Issues Paper made it clear that the Act would require substantial amendment to address the issues raised during the consultation period and that the nature of the changes required, was beyond the review's scope.

In response the scope of the review was expanded to incorporate the development of a new Mental Health Act. A Discussion Paper proposing the development of new legislation was released in September 2007 for a six week consultation period. The Discussion Paper also contained a series of recommendations about the matters that should be included in the new Mental Health Act.

Feedback received in response to the Discussion Paper indicated strong support for the development of a new Mental Health Act. In general, the feedback received also indicated strong support for the recommendations contained within the Discussion Paper.

The Issues and Discussion Papers can be accessed from the Department of Health and Human Services website www.dhhs.tas.gov.au/mentalhealth

The draft exposure Bill has been developed with advice and assistance from both an Advisory and a Drafting Committee.

The Advisory Committee is comprised of health care professionals, the President of the Mental Health Tribunal, the Manager of the Official Visitors Scheme, the Chair of the Mental Health Council of Tasmania and representatives from Advocacy Tasmania Inc. and the Department of Police and Emergency Management.

The Drafting Committee is comprised of representatives from the Departments of Health and Human Services and Justice. Since late 2009 the President of the Mental Health Tribunal has also been a member. The Chair of TasCAG, the Independent Ministerial Advisory Committee on Mental Health, was a member of the Drafting Committee until TasCAG's cessation in mid-2009.

An early Version of the draft Bill was also considered by a group of external quality consultants, Rethinking Mental Health Laws, who were engaged by the Department of Health and Human Services to independently review the Bill from a quality and rights perspective. Rethinking Mental Health Laws made a series of recommendations about how the early draft Bill could be changed to be more reflective of national and international trends in mental health legislation. Each of Rethinking Mental Health Laws' recommendations was considered and adopted by the Drafting Committee and the Bill was amended accordingly.

Specific consultation has also occurred with key internal and external stakeholders including Advocacy Tasmania Inc., Official Visitors and the Office of the Ombudsman, Ambulance Tasmania and Tasmania Police.

Overview

The draft exposure Bill, once finalised and commenced, will replace the current *Mental Health Act 1996*.

The current *Mental Health Act 1996* was drafted alongside the *Guardianship and Administration Act 1995*. Jointly, they replaced the *Mental Health Act 1963* which had previously dealt with both involuntary hospitalisation of mental health patients and guardianship-type matters, along with the treatment of offenders regarded as mentally disordered.

The current *Mental Health Act* provides a framework for the involuntary detention of persons with serious mental illness. It delineates the circumstances in which involuntary detention may be authorised and provides that a patient in an approved hospital may be provided with treatment with the patient's informed consent, if the treatment is authorised by or pursuant to the *Guardianship and Administration Act*, or if the treatment is authorised by the Guardianship and Administration Board pursuant to section 32 of the *Mental Health Act*.

The *Guardianship and Administration Act* in turn establishes a substitute decision-making framework for persons with a disability who are incapable of giving consent to the carrying out of medical treatment. That Act provides that consent to treatment may be given by either a person responsible or by the Guardianship and Administration Board, depending on the circumstances and the nature of the treatment proposed.

The *Mental Health Act* and the *Guardianship and Administration Act* can be accessed from www.thelaw.tas.gov.au

A summary of the key current *Mental Health Act* provisions and the involuntary detention, community treatment and hospital-based treatment pathways established by the *Mental Health Act* and *Guardianship and Administration Act* is provided at Appendix 1 to this document.

The existence of separate legislative regimes for the authorisation of detention and treatment is inconsistent with most other Australian jurisdictions. The existence of two frameworks adds a level of complexity to the treatment framework which appears to be unnecessary, which is confusing and which sometimes requires more than one hearing for the same person. This is both inefficient and can result in unnecessary stress to consumers at a time when they are acutely unwell. Critically, the existence of two separate frameworks permits a person to be involuntarily detained without being treated.

The review process also highlighted the insufficiency of existing review mechanisms. Under the current Act, decisions about detention are reviewed as late as 28 days after they are made, by which time the majority of involuntary detention orders have been discharged. This means that most decisions about detention are never reviewed at all.

Pursuant to the *Guardianship and Administration Act*, 'persons responsible' may make substitute decisions about the provision of psychiatric treatment in respect of a person for whom they are responsible. This is the most common way by which treatment is authorised for persons lacking capacity.

The relevant provisions of the *Guardianship and Administration Act* provide that a person responsible should have a good knowledge of the person, their illness and factors impacting on their illness such that they can make informed judgments about whether to agree to treatment on behalf of the person for whom they are responsible. However, the *Guardianship and Administration Act* does not require the Board to be notified of or to review whether a person responsible really is well placed to make decisions about treatment for the other person. This means that decisions about treatment made by persons responsible pursuant to the *Guardianship and Administration Act* may never be reviewed.

Even when a person responsible is well placed to make decisions about treatment, the experience of many carers and family members is that providing substitute consent to treatment places them under undue pressure and can damage the relationship with the person who has been treated without their consent. This can impinge on their ability to provide care and support for the person into the future.

While the current *Mental Health Act* was drafted with a human rights focus, and incorporates a range of protections that are designed to promote and protect the rights of consumers, the current Act's utilisation has not always reflected this reality. The current *Mental Health Act* also does not clearly reflect recent shifts towards consumer centred care. In particular, the review process clearly highlighted the need for greater clarity around the statutory rights that consumers have, including the right for consumers and support persons to have access to relevant information.

Although the current *Mental Health Act* has been operational now for over a decade, the experience of many health care professionals and other statutory officers required to exercise functions under the legislation is that it does not provide clear guidance on the circumstances and manner in which the functions may and ought to be exercised. For example, there are issues around the use of the protective custody provisions by authorised officers, and confusion surrounding the role of approved medical practitioners and medical practitioners in the involuntary detention process. The review clearly highlighted the need to provide clinicians and other statutory officers with greater clarity around their roles, responsibilities and obligations with a view to promoting the making of consistent and transparent decisions which will, in turn, enhance and protect the fundamental rights of Tasmanians with mental illness.

Key Features of the Draft Bill

The draft exposure Bill represents a significant reform in the legal framework for the treatment and care of persons with serious mental illness in Tasmania. Consistent with national and international trends it has been drafted around a capacity framework, is rights focussed and consumer centred. Crucially, the Bill:

- Does not enable a person with capacity to be treated against their will
- Enables decisions about treatment and treatment setting to be made within one legislative framework and by a single tribunal
- Enables decisions about treatment and treating setting to be made by an independent body
- Establishes a single Treatment Order which enables the authorisation of treatment in either a community or an inpatient setting, or through a combination of settings
- Requires all decisions made under the legislation which effectively infringe a consumer's civil rights to be reported to the independent tribunal so that they can be reviewed as and when required.

The draft Bill retains some features of the current legislation. This includes provisions which did not form part of the scope of the initial review, specifically provisions for the Chief Forensic Psychiatrist and the operation of the secure mental health unit, and for the making of interstate transfer agreements. Other provisions have changed in style but retained their basic substance. This includes provisions for matters including informed consent, the transfer of patients between approved facilities and the authorisation of restrictive practices including seclusion.

The draft Bill also omits some matters which are regulated by the current legislation, most notably the admission of voluntary patients to approved facilities. Provisions for this purpose have not been included in the draft Bill for a range of reasons including:

- Feedback received with respect to this issue through the Issues and Discussion Paper review processes was primarily concerned with failure, at the service delivery level, to afford persons seeking voluntary admission the rights that are already provided for in the current *Mental Health Act*. It is considered that change in this regard is more likely to come through the issuance of standing orders and clinical guidelines by the Chief Civil Psychiatrist, than via legislative regulation.
- There are a range of other mechanisms available for persons who feel that they have been inappropriately refused service (for example, complaint to the Health Complaints Commissioner).
- The regulation of voluntary admissions is at odds with the focus of the new legislation on protecting the rights of incapacitated persons for whom voluntary admission would not be appropriate.

Key features of the Bill are set out below.

Rights Focus

- Objects and principles that are consistent with key international human rights instruments including the *United Nations Convention on the Rights of Persons with a Disability*
- Focus on consumer autonomy through the inclusion of capacity 'tests' and recognition of the importance of enabling individuals to make their own decisions within supported frameworks
- New assessment and treatment criteria which are focussed around a person's ability to make an assessment or treatment decision and which enable individuals to be involuntarily assessed or treated only if there is a lack of decision making capacity in this regard
- Special protections for consumers who are less than 14 years old

Greater Clarity for Consumers, Health Care Professionals and Others

- New meanings for mental illness, assessment and treatment
- Simplified involuntary treatment pathway including streamlined protective custody provisions
- New requirements around when information about a consumer's treatment, care and rights must be provided, and to whom

Shift in Focus from Detention to Community Treatment

- Assessment Orders which enable a person to be assessed involuntarily with regard to an existing or suspected mental illness where this cannot, consistent with the objects of the legislation, be achieved in any other way. The Bill also enables a person to be detained, if necessary, for the purposes of assessment
- Treatment Orders which enable a person to be treated involuntarily for a mental illness and, if necessary, to be detained for that purpose
- Flexibility in achieving changes to treatment setting

Greater Transparency

- Establishment of the independent statutory office of Chief Civil Psychiatrist, whose role will be to provide support and guidance to health care professionals in the performance of statutory and clinical functions
- Clarified record keeping and enhanced reporting requirements
- Specific regulation of special psychiatric treatment

Improved Safeguards and Oversight

- New power of direct intervention for the Chief Civil Psychiatrist and the Chief Forensic Psychiatrist with respect to matters related to consumer treatment and care
- Independent tribunal with the power to make and review Treatment Orders. The Tribunal will also have the power to review Assessment Orders, restrictive practices, transfers between approved facilities, and other matters
- A requirement for Treatment Orders to be reviewed 30 and 90 days after they are made
- Extension of Official Visitor functions to community-based treatment settings

Part 1 and Schedule 1: Preliminary and Mental Health Service Delivery Principles

Part 1 of the draft Bill establishes the legislation's purpose and commencement and defines key terms and meanings. Part 1 also establishes who may consent to assessment or treatment, and the treatment policy which underpins the provisions of the draft Bill.

The purpose of the draft Bill is to provide for the assessment, treatment and care of persons with mental illness. The draft Bill also repeals the *Mental Health Act 1996* and makes consequential amendments to other legislation.

It is intended that the draft Bill will come into effect at least six months after its successful passage through Tasmanian Parliament to allow sufficient time for the new legislation to be implemented. Tasks associated with the legislation's implementation will include establishing the new Mental Health Tribunal, appointing statutory officials, developing necessary supporting documentation and forms, providing education and training to health care professionals and others required to exercise functions under the Act, and developing rights statements and consumer guides to the legislation.

Part 1 of the draft Bill also sets out the objects of the Act and introduces the new legislation's operating principles.

Objects and Principles (Clauses 13, 16, 223 and Schedule 1)

The draft Bill contains a series of new objects and principles. Jointly, the objects and principles establish the lens through which the provisions of the Bill should be interpreted and applied.

The objects and principles contained in the draft Bill are reflective of modern human rights requirements and mental health service delivery priorities. They specifically reflect key elements of the *United Nations Convention on the Rights of Persons with Disabilities* (CRPD), the *Fourth National Mental Health Plan 2009 - 2014* and *National Mental Health Standards 2010*.

Key objects include:

- Providing for appropriate oversight and safeguards in relation to the assessment, treatment and care of persons with a mental illness
- Providing for the assessment, treatment and care of persons with a mental illness in the least restrictive setting consistent with clinical need, legal and judicial constraints, patient health, safety and welfare and public safety
- Promoting voluntary over involuntary assessment and treatment and the making of free and informed assessment and treatment choices

Key principles include:

- Respecting, observing and promoting the inherent rights, liberty, dignity, autonomy, and self-respect of persons with mental illness
- Interfering with or restricting 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
- Promoting the ability of persons with mental illness to make their own choices
- Involving persons receiving services, and where appropriate their families and support persons, in decision making
- Respecting 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.

Key Terms and Meanings (Clauses 3 – 9)

The draft Bill provides specific meanings for key terms and concepts used throughout the Bill. This includes mental illness, assessment, treatment and informed consent. Other relevant definitions may be found in clause 3, including as follows:

- Advocate, of a patient, means someone independent who stands beside and speaks for the patient to protect and promote the patient's interests
- Chemical restraint means medication to control the conduct of the person to whom it is given
- Child means a person under 14 years of age
- General health care means medical, dental or other health treatment not primarily aimed at the treatment or alleviation of mental illness
- Guardian has the same meaning as in the *Guardianship and Administration Act 1995*
- Mechanical restraint means a device that controls a person's freedom of movement
- Parent, of a person under 18 years of age, means the person having, for the person under 18 years of age, all the duties, powers, responsibilities and authority which, by law, parents have in relation to their children
- Physical restraint means bodily force that prevents a person's freedom of movement
- Representative, of a patient or prospective patient, means
  - the patient's guardian,
  - the patient's advocate or lawyer,
  - 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
- Seclusion means the deliberate confinement of an involuntary patient or forensic patient, alone, in a room or area that the patient cannot freely exit
- Support person, of a patient or prospective patient, means a person who provides the patient with ongoing care or support

Each of the key terms effectively establishes a legal "threshold" which will determine whether or not the provisions of the legislation apply to a particular individual or in a particular circumstance.

Meaning of Mental Illness (Clause 4)

The meaning of mental illness contained in the draft Bill has been drafted to cover the range of conditions for which treatment by way of a Treatment Order may be necessary.

The meaning:

- Includes temporary conditions
- Makes it clear that a person may not be taken to have a mental illness by reason only of factors including intoxication, dementia or acquired brain injury.

Clinical guidelines will be developed as part of the draft Bill's implementation to assist health care professionals in determining whether or not a person has a mental illness within the meaning provided in the legislation.

Meaning of Informed Consent (Clause 7)

The meaning of informed consent contained in the draft Bill sets out the matters about which a medical practitioner must be satisfied, before being able to take a person's consent to assessment or treatment as being informed.

The meaning requires the medical practitioner and the prospective consumer to have discussed the proposed treatment. The meaning also requires the prospective consumer to have been given relevant information including any information that is considered by either or both the medical practitioner and the consumer to be of relevant importance, and likely to influence the consumer's decision making with regard to the treatment.

Presumptions Regarding Capacity (Clauses 8 – 9)

Clauses 8 and 9 of the draft Bill establish how a person's decision making capacity, for the purposes of giving or withholding informed consent, can and should be assessed. The provisions require the decision making capacity of adults and young persons to be presumed and provide guidance around how to assess the decision making capacity of a person who is less than 14 years old.

Both clauses are reflective of the Common Law position around decision making capacity as it concerns treatment decisions, and of the mature minor principle.

Who May Consent to Assessment or Treatment and the State Treatment Policy (Clauses 10 and 15)

Clause 10 of the draft Bill establishes who may consent to assessment or treatment. It establishes that:

- Consent to treatment for a person who is less than 14 years old, and who lacks decision making capacity, may only be given by the patient's parent, or a person acting in the place of a parent
- Consent to treatment for a person who is less than 14 years old, and who has decision making capacity, may only be given by that person
- Consent to treatment for a person who is 14 years of age or older may only be given by that person

This is reflective of the draft Bill's focus on autonomy and the right for a person with decision making capacity to make their own assessment and treatment decisions. In particular it recognises that some children will have the ability to make treatment decisions for themselves. It also recognises that an independent tribunal, rather than a person responsible, is best placed to make a treatment decision on behalf of a person who lacks decision making capacity, given the effect of the decision which is to remove or reduce the consumer's rights in this regard.

The State Treatment Policy clarifies the circumstances in which persons may be provided with treatment pursuant to the draft Bill. The Policy is again reflective of the position that a person with capacity to provide informed consent to treatment may only be provided with treatment if there is either informed consent, or if the treatment is authorised pursuant to the provisions of the draft Bill.

Part 2: Administration

Part 2 of the draft Bill establishes the statutory offices of Chief Civil Psychiatrist and Chief Forensic Psychiatrist. It also provides for the statutory offices of approved nurse and approved medical practitioner, and for the approval of mental health facilities.

Chief Psychiatrists (Clauses 18 – 28)

The draft Bill establishes the statutory offices of Chief Civil Psychiatrist and Chief Forensic Psychiatrist. The relevant provisions require the incumbents to each office to be a psychiatrist of at least five years standing, and a Fellow of the Royal Australian and New Zealand College of Psychiatrists.

Each Chief Psychiatrist has a general overall responsibility for ensuring that the objects of the legislation are met in respect of patients within their jurisdiction:

- For the Chief Civil Psychiatrist this extends to patients other than forensic patients or persons who are subject to supervision orders, and the running of approved facilities other than secure mental health units
- For the Chief Forensic Psychiatrist this extends to forensic patients and persons who are subject to supervision orders, and the running of secure mental health units.

Each Chief Psychiatrist has the ability to directly intervene with respect to the treatment and care of any patient, and to issue standing orders and clinical guidelines with respect to any matter within his or her jurisdiction.

The specific powers and functions of each Chief Psychiatrist are referred to throughout the draft Bill and include the authorisation of urgent circumstances treatment, and the authorisation of seclusion or restraint for a patient who is less than 14 years old.

Each Chief Psychiatrist is required to provide the Minister with an annual report on his or her activities during the preceding year.

Mental Health Facilities (Clauses 29 – 30)

The draft Bill enables the Minister for Health to approve premises as hospitals, assessment centres and secure mental health units for the purposes of the legislation. The draft Bill requires the Minister to be satisfied that premises which are approved for this purpose are properly built, equipped and staffed.

Approved Personnel (Clauses 31 – 32)

The draft Bill enables either or both the Chief Civil Psychiatrist and Chief Forensic Psychiatrist to approve persons as medical practitioners and nurses for provisions of the legislation within the Chief Psychiatrist's jurisdiction. The Bill requires the Chief Psychiatrist to be satisfied that the persons so approved are appropriately qualified or experienced.

The intention is to approve only psychiatrists or medical practitioners who otherwise have significant experience in the diagnosis or treatment of mental illness as approved medical practitioners for the purpose of the legislation, and to approve only registered nurses with mental health or related qualifications or significant experience in the treatment and care of persons with mental illness, as approved nurses for the purpose of the legislation.

The draft Bill also provides for the appointment of individuals or classes of individuals as mental health officers for the purposes of the legislation. The draft Bill requires persons who are so approved to have skills, qualifications or experience relevant to the responsibilities of mental health officers under the relevant provisions of the legislation. This includes taking persons into protective custody and exercising escort and custodian functions as may otherwise be required.

Part 3 and Schedule 2: Protective Custody and Custody and Escort Provisions

Part 3 of the draft Bill regulates the circumstances and manner in which persons may be taken into protective custody. The protective custody provisions specifically enable front line health care professionals, and police officers, to take immediate action to have a person who they reasonably think is experiencing a mental health crisis examined, to determine whether or not they should be involuntarily assessed and/or treated.

Entry to Protective Custody (Clauses 33 – 36)

The draft Bill provides that a person may be taken into protective custody if a mental health officer or police officer reasonably believes that:

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

The draft Bill requires a person who has been taken into protective custody to be taken to an approved assessment centre where the person may be examined by a medical practitioner to determine whether or not he or she needs to be assessed against the assessment or treatment criteria.

The assessment and treatment criteria are set out in Part 4 of the draft Bill and further on in this document.

The draft Bill makes it clear that a person's protective custody may be handed over, that a person who is in protective custody must be given a statement of rights, and that a person must be examined within four hours of arriving at the approved assessment centre.

Release from Protective Custody and Record Keeping (Clauses 37 – 38)

The draft Bill requires a person to be released from protective custody if:

- Informed consent is given for the person's assessment or treatment
- An Assessment or Treatment Order is made
- The mental health officer or police officer who has the person in protective custody reasonably forms the belief that the person no longer meets the criteria for being taken into protective custody
- More than four hours have passed since the person's arrival at the assessment centre.

The draft Bill also requires instances of protective custody and matters relevant to the person's examination while in protective custody, to be recorded. Copies of the record must be provided to the person concerned, and to the Chief Civil Psychiatrist.

Powers and Duties of Custodians and Escorts (Schedule 2)

Schedule 2 of the draft Bill sets out the powers and duties of police officers, mental health officers or authorised persons who, by or under the legislation, are empowered or authorised to take a patient or prospective patient into protective custody or under escort.

Key powers and duties listed in Schedule 2 include the following:

- The ability for a custodian or escort to enlist the assistance of any person, including if necessary a police officer
- The ability for a custodian or escort to use reasonable force in appropriate circumstances
- The ability for a custodian or escort to enter premises without a warrant
- The ability for a custodian or escort to transfer physical control of the patient to another custodian or escort or to another police officer, mental health officer or authorised person.

Schedule 2 also contains a custody and escort policy which provides for matters including that, as far as is practicable:

- Patients should not be taken into protective custody if they can be properly examined and assessed against the assessment or treatment criteria without being taken into protective custody
- Patients should not be taken into or held in protective custody or taken or held under escort by force if there are other options available
- The use of non-police custodians, escorts and assistants is to be preferred.

Part 4: Involuntary patients

Part 4 of the draft Bill establishes the criteria upon which a person may be involuntarily assessed or treated, and sets out the involuntary treatment pathway. Specifically, it provides for Assessment and Treatment Orders and their effects, and sets out the circumstances in which these may be applied for, made, amended and discharged.

Part 4 also provides for matters relevant to the treatment of involuntary patients including the rights of involuntary patients in approved hospitals.

Treatment Order Pathway

Assessment Orders (Clauses 38 – 53)

Part 4 Division 1 of the draft Bill regulates the nature, making and effect of Assessment Orders.

Assessment Order pathway

The Assessment Order pathway anticipated by the draft Bill is as follows:

- An Assessment Order may be applied for by:
  - A medical practitioner
  - A nurse
  - A mental health officer
  - A police officer
  - A guardian, parent or support person
- An Assessment Order may be made by a medical practitioner who is in receipt of an application, and who has examined the consumer
- Once made, an Assessment Order is authority for the patient to be assessed by an approved medical practitioner and for the patient to be taken under escort by a mental health officer or police officer and, if necessary, to be admitted to, and involuntarily accommodated in, an approved hospital for and in connection with the assessment
- The purpose of the approved medical practitioner's assessment is to confirm whether or not the patient meets the assessment criteria and see if the patient also meets the treatment criteria
- The approved medical practitioner's assessment must occur within 24 hours of the Order being made, and a decision must be made at that point about whether or not the Order should be affirmed or discharged
- If the approved medical practitioner does not assess the person within 24 hours of the Order having been made, the Order ceases
- If the approved medical practitioner affirms the Order he or she may extend the Order's operation by a period of up to 72 hours commencing from the time of the affirmation
- An Assessment Order may be discharged at any time by the medical practitioner who made it, by any approved medical practitioner, or by the Tribunal
- An Assessment Order that has been affirmed and extended lasts until the end of the period for which it has been extended, until it is discharged, or until a Treatment Order is made, whichever occurs first, and may not in any circumstances last for longer than 96 hours.

Assessment Criteria

The draft Bill provides two sets of assessment criteria. This is to cover both persons who are known to have a mental illness which requires or is likely to require treatment, and persons who appear to have a mental illness which, if confirmed, will require or is likely to require treatment. The criteria are either:

- the person has a mental illness that requires or is likely to require treatment for:
  - the person's health or safety, or
  - the safety of other persons, and
- the person cannot be properly assessed with regard to the mental illness or the making of a Treatment Order except under the authority of the Assessment Order, and
- the person does not have the mental capacity to give informed consent to the assessment

OR

- the person appears to have a mental illness that, if confirmed, will require or is likely to require treatment for:
  - the person's health or safety, or
  - the safety of other persons, and
- the person cannot be properly assessed with regard to the apparent mental illness or the making of a Treatment Order except under the authority of the Assessment Order, and
- the person does not have the mental capacity to give informed consent to the assessment.

The assessment criteria will be met if either of the sets of criteria are satisfied.

Key safeguards

The safeguards established by the draft Bill in relation to the making of Assessment Orders are as follows:

- A person may only apply for an Assessment Order if satisfied that the person has or might have a mental illness and should be examined to see if they need to be assessed against the assessment criteria. The applicant should also be satisfied that a reasonable attempt to have the person assessed with their informed consent has failed, or that it would be futile or inappropriate to make such an attempt
- A medical practitioner may only make an Assessment Order if in receipt of an application which the practitioner is satisfied meets these requirements
- A medical practitioner may only make an Assessment Order if he or she is satisfied that the person needs to be assessed against the assessment criteria and that a reasonable attempt to have the person assessed with informed consent has failed, or that it would be futile or inappropriate to make such an attempt
- A medical practitioner may only make an Assessment Order which requires the involuntary accommodation of a patient who is less than 14 years of age in an approved hospital if the practitioner is satisfied that the hospital has facilities and staff to assess the patient, and that the hospital is, in the circumstances, the most appropriate place to accommodate the patient
- The medical practitioner who makes an Assessment Order and the approved medical practitioner who assesses the patient under the Assessment Order to see whether the assessment criteria are met, must be different people

- The approved medical practitioner's assessment must occur within 24 hours of the Assessment Order having been made, and a decision must be made at that point, about whether or not the Order should be affirmed or discharged
- An Assessment Order may only be affirmed if the practitioner is satisfied that the patient meets the assessment criteria, that a reasonable attempt to have the patient treated on a voluntary basis has failed, or that it would be futile or inappropriate to attempt to obtain the patient's consent
- An approved medical practitioner who affirms or discharges an Assessment Order is to give notice of the affirmation and extension of the Order (if relevant) to the patient, the Chief Civil Psychiatrist and the Mental Health Tribunal (thereby enabling the Chief Civil Psychiatrist to directly intervene and/or for the Tribunal to review the Order)
- An Assessment Order may be discharged at any time
- An Assessment Order will be taken to have been automatically discharged if and when informed consent is given for the patient to be assessed or treated
- Matters relevant to the Assessment Order must be recorded on the patient's clinical record.

Treatment Orders (Clauses 54 – 70)

Part 4 Division 2 of the draft Bill regulates the nature, making and effect of Treatment Orders.

Treatment Order pathway

The Treatment Order pathway anticipated by the draft Bill is as follows:

- A Treatment Order may only be made if applied for by an approved medical practitioner
- A Treatment Order may only be made by the Tribunal
- The Tribunal must consider an application for a Treatment Order no later than seven days after the Assessment Order to which the patient is subject, lapses
- A single Tribunal member may however make an interim Treatment Order if the delay associated with waiting for the full Tribunal to consider the application would, or is likely to, seriously harm the patient's health or safety, or the safety of other persons
- An interim Treatment Order lapses after seven days if, by then, the full Tribunal has not considered the application
- A Treatment Order takes effect as soon as it is made and continues in effect, unless it is sooner discharged, for up to six months
- A Treatment Order is authority for the patient to be given the treatment specified in the Order
- The terms of a Treatment Order may also enable the patient to be escorted to an approved facility and/or to be admitted to and involuntarily accommodated in an approved facility for and in connection with the treatment that the Order authorises
- A patient who fails to comply with a Treatment Order may be taken under escort by a mental health officer or police officer to ensure that he or she presents for treatment, and/or be involuntarily admitted to, and accommodated in, an approved facility for an in connection with the treatment that the Order authorises
- Application may also be made in respect of a patient who fails to comply with a Treatment Order, for a variation to the Order, and/or for urgent circumstances treatment

- A Treatment Order may be varied by the Chief Civil Psychiatrist provided the variation does not make the Order more restrictive of the patient's rights, privileges and freedom of action
- A Treatment Order may also be varied by the Tribunal and may only be varied by the Tribunal if the variation makes the Order more restrictive of the patient's rights, privileges and freedom of action
- A Treatment Order lasts for up to six months and may be renewed on the application of any approved medical practitioner:
  - An Order that has not previously been renewed may be renewed for up to six months
  - An Order that has previously been renewed may be renewed for up to twelve months
- A Treatment Order may be discharged at any time by any approved medical practitioner or by the Tribunal
- A Treatment Order is automatically discharged if informed consent is given for the patient's treatment.

Treatment criteria

The treatment criteria are that:

- The patient has a mental illness
- Without treatment, the mental illness will, or is likely to, seriously harm:
  - The patient's health or safety, or
  - The safety of other persons
- The treatment will be appropriate and effective in terms of the treatment outcomes referred to in the meaning of treatment provided for in the draft Bill
- The treatment cannot be adequately given except under a Treatment Order
- The patient does not have the mental capacity to give informed consent to the treatment.

Key safeguards

The safeguards established by the draft Bill in relation to the making of Treatment Orders are as follows:

- An approved medical practitioner may only apply for a Treatment Order in respect of a person who is, at the time that the application is made, subject to an Assessment Order
- An approved medical practitioner may only apply for a Treatment Order if he or she has assessed the patient under the authority of the Assessment Order and is satisfied from the assessment that the patient meets the treatment criteria
- A Treatment Order may only be made in respect of a person who is considered by both the approved medical practitioner who applies for the Order, and by the Tribunal, to be lacking mental capacity to give informed consent to the treatment the subject of the Treatment Order
- The Tribunal must consider an application for the making or renewal of a Treatment Order as soon as practicable after the application is received, and must do so by way of a hearing before a division of the Tribunal constituted by three members
- An application for a Treatment Order lapses within seven days of the relevant Assessment Order ceasing to have effect, if the Tribunal fails to determine the application for a Treatment Order within that time

- The Tribunal may only make a Treatment Order if satisfied that the patient meets the treatment criteria, that a reasonable attempt to have the patient treated with informed consent has failed, or if the Tribunal is satisfied that it would be futile or inappropriate to make such an attempt
- The Tribunal may only make a Treatment Order which requires the involuntary accommodation of a patient who is less than 14 years of age in an approved hospital if the Tribunal is satisfied that the hospital has facilities and staff for the treatment and care of the patient, and that the hospital is, in the circumstances, the most appropriate place available to accommodate the patient
- A single member of the Tribunal may make an interim Treatment Order (which does not require a hearing) but may only do so:
  - While the Assessment Order to which the patient is subject remains in effect
  - If the member is satisfied that the Tribunal could not immediately determine the application, and
  - If satisfied that the delay that would be involved in awaiting a decision of the Tribunal should the interim Treatment Order not be made would, or is likely to, seriously harm the patient's health or safety, or the safety of other persons.
- An interim Treatment Order lapses after seven days if, by that time, the Tribunal has not determined the application for the Treatment Order
- An approved medical practitioner who applies to the Tribunal to have a Treatment Order made or renewed must give a copy of the application to the patient, together with a statement of rights
- A Treatment Order may only be renewed if the relevant Treatment Order is still in effect
- The Tribunal must give a patient in respect of whom a Treatment Order is made or renewed notice to that effect and a copy of the Order, together with a statement of rights
- The controlling authority of an approved facility to which a patient who has failed to comply with the terms of a Treatment Order is admitted must notify the Tribunal and the Chief Civil Psychiatrist of the patient's admission (this enables the Chief Civil Psychiatrist to directly intervene with respect to the matter and/or for the Tribunal to review the Order)
- Matters relevant to the Treatment Order must either be recorded on the patient's clinical record or reported to the Chief Civil Psychiatrist.

Medical and Non-Medical Treatments

Treatment Plans (Clauses 71 – 75)

The draft Bill requires the Chief Civil Psychiatrist to ensure that each involuntary patient has a treatment plan, where this is defined as an instrument that sets out the outcome of a patient's assessment and how the treatment specified in the patient's Treatment Order is to be provided.

The draft Bill requires a medical practitioner who prepares or varies a patient's treatment plan to consult with the patient. The Bill also enables a practitioner to consult with other persons as the practitioner thinks fit in the circumstances, but only after consulting with the patient in this regard.

The Bill requires a copy of the treatment plan and notice of any variation to the plan to be given to the patient and the Chief Civil Psychiatrist, and for a copy of the plan and/or notice of the variation to the plan, to be placed on the patient's clinical record.

Urgent Circumstances Treatment (Clause 76)

The draft Bill enables an involuntary patient to be given treatment without informed consent or Tribunal authorisation if the Chief Civil Psychiatrist authorises it as being urgently needed in the patient's best interests.

The involuntary treatment pathway anticipated by the new legislation effectively prevents a consumer who is experiencing acute mental illness but who lacks capacity to provide their own consent to treatment, from being provided with treatment that is necessary for their health or safety, or the safety of others, until such time as a Treatment Order is made. The draft Bill enables the authorisation of treatment in these circumstances.

The urgent circumstances clause may also have application for patients who are already subject to a Treatment Order, for whom the treatment authorised by way of the Order is no longer appropriate, and in relation to whom different treatment is urgently required.

The draft Bill enables the Chief Civil Psychiatrist to authorise urgent circumstances treatment for an involuntary patient if, and only if:

- An approved medical practitioner has assessed the patient, and has concluded from that assessment, that the urgent circumstances treatment is necessary for the patient's health or safety, or the safety of others, and that achieving the necessary treatment outcomes would be compromised by waiting for the urgent circumstances treatment to be authorised by the Tribunal
- The Chief Civil Psychiatrist:
    - Agrees with the approved medical practitioner's conclusions, and
    - Is satisfied that a reasonable attempt to give the patient the treatment with informed consent has failed, or that it would be futile or inappropriate to make such an attempt.

The draft Bill enables urgent circumstances treatment to be given for a maximum of up to 96 hours. The authorisation may also be sooner revoked or set aside by the Tribunal.

The draft Bill puts in place several safeguards in relation to the authorisation of urgent circumstances treatment including a requirement that the patient and Tribunal be given a copy of the authorisation (enabling the Tribunal to conduct a review). A copy of the authorisation must also be placed on the patient's clinical record.

The draft Bill also prevents urgent circumstances treatment from being given to a patient if less than 30 days has passed since the last time that the patient was given treatment of that kind, or if the Tribunal has previously refused to sanction the particular kind of treatment for the patient.

The draft Bill makes it clear that the urgent circumstances provisions are not intended to override or otherwise limit the operation of section 40 of the *Guardianship and Administration Act*, which enables medical treatment to be given to a person with a disability who is incapable of giving consent to the carrying out of the medical treatment, if the medical practitioner consider it to be necessary, <u>as a matter of urgency</u>, to save the person's life, to prevent serious damage to the person's health, or to prevent the person from suffering or continuing to suffer significant pain or distress.

Seclusion and Restraint (Clauses 3 and 77 – 79)

As with the current *Mental Health Act* the draft Bill enables an involuntary patient to be secluded or restrained in certain prescribed circumstances.

Unlike the current *Mental Health Act* the draft Bill differentiates between types of restraint. It also acknowledges and regulates the use of chemical restraint.

The draft Bill acknowledges that medications are sometimes given to individuals to control their conduct. The draft Bill very closely defines the circumstances in which this may occur and puts parameters around how and by whom the use of medications for this purpose may be authorised. In particular, the draft Bill prevents a person from being chemically restrained unless the practice is authorised by, and managed in accordance with, the provisions of the Bill.

The draft Bill requires the use of chemical restraint to be authorised by the Chief Civil Psychiatrist and puts limitations around how long a person may be chemically restrained for. The Bill requires persons who are chemically restrained to be regularly observed and examined, and imposes reporting and record keeping obligations on health care professionals in respect of this practice.

It is expected that the specific regulation of chemical restraint by the draft Bill will reduce the use of medications to control the behaviour of individuals, particularly given the safeguards that the draft Bill imposes on the authorisation of restraint generally, and chemical restraint particularly.

The draft Bill builds upon safeguards that are contained within the provisions of the current *Mental Health Act* around the use of restrictive practices by introducing a range of new safeguards:

- The seclusion or restraint of a patient who is less than 14 years old must be authorised by the Chief Civil Psychiatrist
- The mechanical or chemical restraint of any patient must be authorised by the Chief Civil Psychiatrist
- The person authorising the seclusion or restraint must be satisfied that it is a reasonable intervention in the circumstances
- In the case of physical restraint, the means of restraint used must be approved in advance by the Chief Civil Psychiatrist
- The seclusion or restraint of any person for more than seven hours must be authorised by the Chief Civil Psychiatrist, and any extension of seclusion or restraint beyond seven hours may be conditional
- A person who has been secluded or restrained for more than twelve hours must be examined by an approved medical practitioner within that period
- The seclusion or restraint must not be maintained to the obvious detriment of the patient's mental or physical health
- A patient must not be secluded or restrained as a means of punishment, or for reasons of mere administrative or staff convenience
- The authorisation of seclusion or restraint must be recorded, and a copy of the record must be given to the Chief Civil Psychiatrist and the Mental Health Tribunal (this enables the Chief Civil Psychiatrist to directly intervene with respect to the matter and/or for the Tribunal to conduct a review).

The draft Bill also makes it clear that a patient's seclusion should not be taken to have been interrupted by way of a scheduled observation or examination, or the giving of any necessary treatment or general health care.

Rights (Clause 83)

The draft Bill prescribes the rights of involuntary patients in approved hospitals. They include the right for involuntary patients to:

- Have restrictions on, and interference with, their dignity, rights and freedoms kept to the minimum consistent with their health or safety and the safety of other persons
- Have their decision making capacity promoted, and their wishes respected, to the maximum consistent with their health or safety and the safety of other persons
- Be given clear, accurate and timely information about their rights as an involuntary patient, the rules and conditions governing their conduct in the hospital, and their diagnosis and treatment
- Have contact with, and to correspond privately with, their representatives and support persons, and with Official Visitors

Part 5: Forensic Patients

As noted above provisions for the management of forensic patients and the operation of secure mental health units were introduced to the Act in 2005. Given this, the review process associated with the current *Mental Health Act* did not involve seeking stakeholder feedback on the forensic provisions.

On this basis, Part 5 of the Bill substantially replicates Parts 10A and 10B of the current *Mental Health Act*. The language and style of the provisions has however been updated to reflect the plain English, modern style in which the draft Bill has been developed. The language and structure of some provisions has changed significantly as a result of this process. This includes in particular the following clauses:

- Clause 94: urgent circumstances treatment
- Clauses 98 – 102: seclusion, restraint and the use of force
- Clauses 85 and 107 – 116: visits, telephone calls and mail
- Clause 124: screening of persons seeking entry to the secure mental health unit
- Clauses 125 – 128: search and seizure

Part 6: Special Psychiatric Treatment

Part 6 of the draft Bill regulates the giving of treatment which is defined as special psychiatric treatment. This specifically includes psychosurgery and any other treatment that is declared by the regulations to be special psychiatric treatment.

The draft Bill provides that a voluntary patient, involuntary patient or forensic patient may only be given special psychiatric treatment if:

- The treatment has been authorised, beforehand and in writing, by the Tribunal, and
- If the treatment is psychosurgery or treatment that the regulations specify as requiring informed consent, informed consent has been given to the treatment.

The draft Bill requires the Tribunal to be satisfied of a range of matters before authorising special psychiatric treatment, including:

- That the patient has been assessed by an approved medical practitioner
- That the approved medical practitioner is satisfied that the treatment is necessary, and
- That either the Chief Civil or Chief Forensic Psychiatrist, and an independent expert, agree with the approved medical practitioner's conclusions.

The draft Bill also requires the Tribunal to conduct a hearing involving at least three Tribunal members when considering whether or not to authorise special psychiatric treatment, and enables authorisation to be given only if the members vote unanimously in favour of the treatment.

The draft Bill requires the treating medical practitioner to make a record of any special psychiatric treatment that is given, to place a copy of the record on the patient's clinical record, and to give a copy of the record to the relevant Chief Psychiatrist and the Tribunal.

The draft Bill makes it an offence for a person to be provided with special psychiatric treatment outside of the framework established by the legislation.

Part 7: Information

Part 7 of the draft Bill establishes the circumstances in which information must be provided to patients, when information about patients may be provided to others including support persons, and other related matters.

The requirements of Part 7 are in addition to the requirements that the legislation otherwise imposes.

Giving of Information (Clauses 143 – 145, 150 – 151)

Part 7 specifically requires:

- A statement of rights to be given to a person whenever they are admitted to or discharged from an approved facility as a patient
- Notification of an involuntary or forensic patient's admission, transfer or discharge, or impending admission, transfer and discharge, to, between or from an approved hospital or secure mental health unit to be given to at least one interested person, where this may be either a known representative, known support person or any other person that the controlling authority of the relevant facility regards as having a proper interest in the patient's welfare
- Notification of an involuntary or forensic patient's impending leave of absence from an approved hospital or secure mental health unit, unlawful absence from an approved hospital or secure mental health unit, or contravention of a condition of leave of absence from an approved hospital or secure mental health unit to be given to at least one interested person, where this may be either a known representative, known support person or any other person that the controlling authority of the relevant facility regards as having a proper interest in the patient's welfare
- The controlling authority of an approved facility to give the Mental Health Tribunal and the Chief Civil Psychiatrist a report on the accommodation and treatment of persons who have been voluntary inpatients of the relevant approved facility for more than four continuous months (enabling the Chief Civil Psychiatrist to directly intervene and/or for the Tribunal to conduct a review)
- Information that is given to a patient who is under the age of 18 and who raises no objection, to also be given to the patient's parent.

Withholding of Information (Clauses 146 – 148)

Clause 146 of the draft Bill enables information which may harm the patient's health or safety, compromise the patient's care or treatment or place the safety of other persons at risk to be withheld or qualified or for the giving of the information to be deferred.

Clause 148 prevents confidential or personal client information from being disclosed except in certain defined circumstances.

Part 8 and Schedule 5: Official Visitors

Part 8 of the draft Bill provides for the appointment, functions and powers of Official Visitors.

The Official Visitors provisions of the draft Bill introduce a model of operation that is slightly different to that established under the current *Mental Health Act* insofar as the Bill provides for an Official Visitor and a Deputy Official Visitor along with the ability for the Official Visitor to delegate any official visitor function by any person who is prima facie eligible to be appointed as the Official Visitor. In practice it is anticipated that the majority of Official Visitor functions would be performed by delegates in this manner. Benefits associated with this model are anticipated to be greater accountability and flexibility in the performance of Official Visitor functions.

Part 8 also makes it clear that the Official Visitor has the power to visit premises from which a patient is being provided with services under the legislation, whether or not those premises are approved, if asked to do so by the patient or a known representative or support person of the patient, or by the Minister. This includes community-based treatment sites. Part 8 also makes it clear that patients, or their representatives or support persons, are able to make a complaint to the Official Visitor.

Part 8 requires the Official Visitor to give the Minister reports on a monthly and annual basis, on the performance of Official Visitor functions during the preceding period. The Minister is in turn required to table the annual report in Tasmanian Parliament. The draft Bill also enables the Official Visitor to give the Minister or relevant Chief Psychiatrist a private report on any matter related to Official Visitor functions.

Part 9: Intergovernmental Agreements

As with the provisions for the management of forensic patients and the operation of secure mental health units, the review process associated with the current *Mental Health Act* did not involve seeking stakeholder feedback on the provisions of the Act concerned with intergovernmental agreements.

On this basis Part 9 of the current Bill substantially replicates Part 12 of the current *Mental Health Act*. The language and style of the provisions has however been updated to reflect the plain English, modern style in which the draft Bill has been developed.

Despite a history of negotiation Tasmania does not yet have any intergovernmental agreements. The development of intergovernmental agreements with other States and Territories will however be a key component of the new legislation's implementation.

Part 10 and Schedules 3 and 4: Mental Health Tribunal and Tribunal Membership and Proceedings

Part 10 of the draft Bill provides for the establishment, functions and powers of the Mental Health Tribunal while Schedules 3 and 4 provide for the Tribunal's membership and proceedings respectively.

Key features of Part 10 and Schedules 3 and 4 include:

- The requirement for at least one member of the Tribunal to be an approved medical practitioner (clause 175)
- The ability for the Tribunal to issue guidelines on matters within its jurisdiction (clause 177)
- The ability for the Tribunal to make interim orders or determinations on the adjournment of any proceedings (clause 180)
- The inclusion of patients, the patient's representatives and any other person who the Tribunal considers to have a proper interest in the relevant proceedings as persons with standing (Schedule 4)
- The entitlement for any party to proceedings to attend hearings held in those proceedings and/or to be represented by an Australian legal practitioner, advocate or other person (Schedule 4)
- The ability for the Tribunal to make arrangements for the representation of a patient considered to be personally incapable of making those arrangements (Schedule 4)
- The ability for the Tribunal to make arrangements for the representation of any other parties to proceedings (Schedule 4)
- The ability for the President of the Tribunal to issue, vary, revoke and/or publish practice directions (Schedule 4)
- The specific ability for the Tribunal to state in the form of a special case for determination by the Supreme Court, any question of law that may arise in the hearing or determination of any proceedings (clause 181)
- The specific ability for a person who a party to any proceedings of the Tribunal to appeal to the Supreme Court from any determination made in those proceedings on a question of law as a matter of right and on any other question with the leave of the Court (clauses 182 and 184)
- The ability for the Tribunal to review matters including the following:
    - The making of Assessment Orders (clause 189)
    - Treatment Orders and their variation and discharge (clause 190)
    - The admission of involuntary patients to secure mental health units (clause 191)
    - The refusal by the Chief Forensic Psychiatrist to return forensic patients to the custody of the Director of Corrections or the Secretary (Youth Justice) (clause 192)
    - The status of voluntary inpatients (clause 193)
    - The admission of a prisoner or youth detainee to the secure mental health unit (clause 194)
    - The giving of urgent circumstances treatment to any involuntary or forensic patient (clause 195)
    - The placement of any involuntary or forensic patient under seclusion or restraint (clause 196)
    - The application of force to any forensic patient (clause 197)
    - The withholding, from any patient, of information by persons other than the Tribunal (clause 198)

- The transfer of any involuntary or forensic patient within Tasmania (clause 199)
- Matters relevant to leave of absence for any involuntary or forensic patient who is not subject to a restriction order (clause 200)
- The exercise of visiting, correspondence or telephone rights by any forensic patient (clause 201)
- The exercise of a Chief Psychiatrist's power of direct intervention

- In relation to the review of Treatment Orders the draft Bill specifically requires the Tribunal to conduct a review:
  - Within 30 days of the Order having been made, if the Order is still in effect at that time
  - Within 90 days of the Order having been made, if the Order is still in effect at that time
  - Within three days of the person's admission to an approved hospital in the event of failure to comply
  - At any other time on its own motion or on the application of any person with the necessary standing
- In relation to the review of voluntary inpatients the draft Bill requires the Tribunal to conduct a review of the patient's status once the patient has been a voluntary inpatient for six continuous months and at six monthly intervals thereafter. The Tribunal may also conduct a review at any other time on its own motion or on the application of any person with the necessary standing
- The Tribunal is required, if asked to do so by a person with the necessary standing, to conduct a review of matters including any instance of seclusion or restraint, the application of force to a forensic patient, the withholding of information, the transfer of an involuntary or forensic patient within Tasmania, determinations relating to leave of absence and the exercise of visiting, telephone or correspondence rights.

Part 11: Miscellaneous

Part 11 of the draft Bill regulates a range of matters which do not clearly sit within any of the Bill's other Parts. This includes remote medical procedures, immunities, delegations, special powers of ambulance officers who are acting as mental health officers for the purpose of the legislation, and conflicts of interest.

Special Powers of Ambulance Officers (Clause 211)

This clause of the draft Bill provides ambulance officers who are transporting any patient by ambulance and acting as mental health officers under the legislation in so doing, with the power to sedate the patient if the ambulance officer reasonably considers it necessary.

The draft Bill requires an ambulance officer who sedates a person pursuant to the clause to give the Chief Civil Psychiatrist a report of the matter.

The purpose of this clause is to enable patients who are experiencing acute distress because of a mental illness, and in relation to whom the powers of the legislation are being exercised for the purpose of transport, to be sedated as may be clinically necessary, by an ambulance officer so as to reduce the risk that the person may pose to themselves or to others, including the ambulance officers conducting the transport function, because of their level of distress and given the confined ambulance environment.

Appendix 1: *Mental Health Act 1996* Provisions and Explanation of Involuntary Detention, Community Treatment and Hospital-Based Treatment Pathways

The *Mental Health Act 1996* contains provisions for:

- Key terms used throughout the Act (section 3)
- The meaning of 'mental illness' (section 4)
- The meaning of 'person responsible' (section 5)
- The meaning of 'informed consent' (section 5AA)
- The Act's objects and principles (sections 6 and 7)
- The approval of hospitals, assessment centres and secure mental health units (sections 9 – 11)
- The appointment, role, powers and functions of the Chief Forensic Psychiatrist (sections 11A – 11C)
- The approval of medical practitioners and authorised officers (sections 12 – 13)
- Delegations (sections 14 and 14A)
- Taking a person into protective custody (sections 15 – 16)
- The admission of persons with a mental illness to an approved hospital (sections 17 – 18)
- Voluntary admission to hospital (sections 19 – 23)
- Involuntary admission to hospital (Initial and Continuing Care Orders) (sections 24 – 30)
- Medical treatment of patients in approved hospitals (sections 31 and 32)
- 'Non-medical' treatment of involuntary patients in approved hospitals (seclusion, restraint, leaves of absence, transfer between hospitals) (sections 34 – 39)
- Community Treatment Orders (sections 40 – 44C)
- Involuntary patients' rights to information (section 45 – 47)
- The establishment, functions, proceedings, members and staff of the Mental Health Tribunal (sections 48 – 69 and Schedule 1)
- Notification and reporting requirements (sections 70 – 72)
- Secure mental health units, the management of forensic patients and the establishment, functions, proceedings, members and staff of the Forensic Tribunal (sections 72A – 74O and Schedule 1A)
- The appointment, functions, visits and reports of Official Visitors (sections 74P – 81)
- Agreements for the humanitarian transfer and apprehension and return of absconding patients (sections 82 – 83G)
- Offence and other miscellaneous provisions (sections 84 – 95)

Involuntary Detention Pathway

Protective Custody (Sections 15 and 16)

The protective custody provisions of the Act enable a police officer or authorised officer to take a person who the officer considers on reasonable grounds to have a mental illness such that there is, in consequence, a serious risk of harm to the person or others, into protective custody.

A person who is taken into protective custody in this manner must be taken to an assessment centre as soon as possible. The person may be held at the assessment centre for a period of up to four hours so that he or she may be examined and diagnosed by a medical practitioner. The person must however be released after four hours if an order for the person's involuntary admission to an approved hospital has not been made.

The Act provides police officers and authorised officers exercising protective custody powers under the Act to enter premises where the person is reasonably considered to be, to use reasonable force, and to be accompanied by an assistant or a police officer.

Involuntary Admission (Sections 24 – 30)

Application for a person's involuntary detention in an approved hospital may be made by a person responsible or an Authorised Officer.

A person may be involuntarily detained in an approved hospital by way of either an Initial Order, which may be made by a medical practitioner or by way of a Continuing Care Order, which may be made by two medical practitioners, one of whom must be an approved medical practitioner, provided the practitioner (or practitioners, as the case may be) consider the involuntary detention criteria to be met.

The involuntary detention criteria are set out in section 24, and will be met if:

- the person appears to have a mental illness; and
- there is, in consequence, a significant risk of harm to the person or others; and
- the detention of the person as an involuntary patient is necessary to protect the person or others; and
- the approved hospital to which admission is proposed is properly equipped and staffed for the care or treatment of the person.

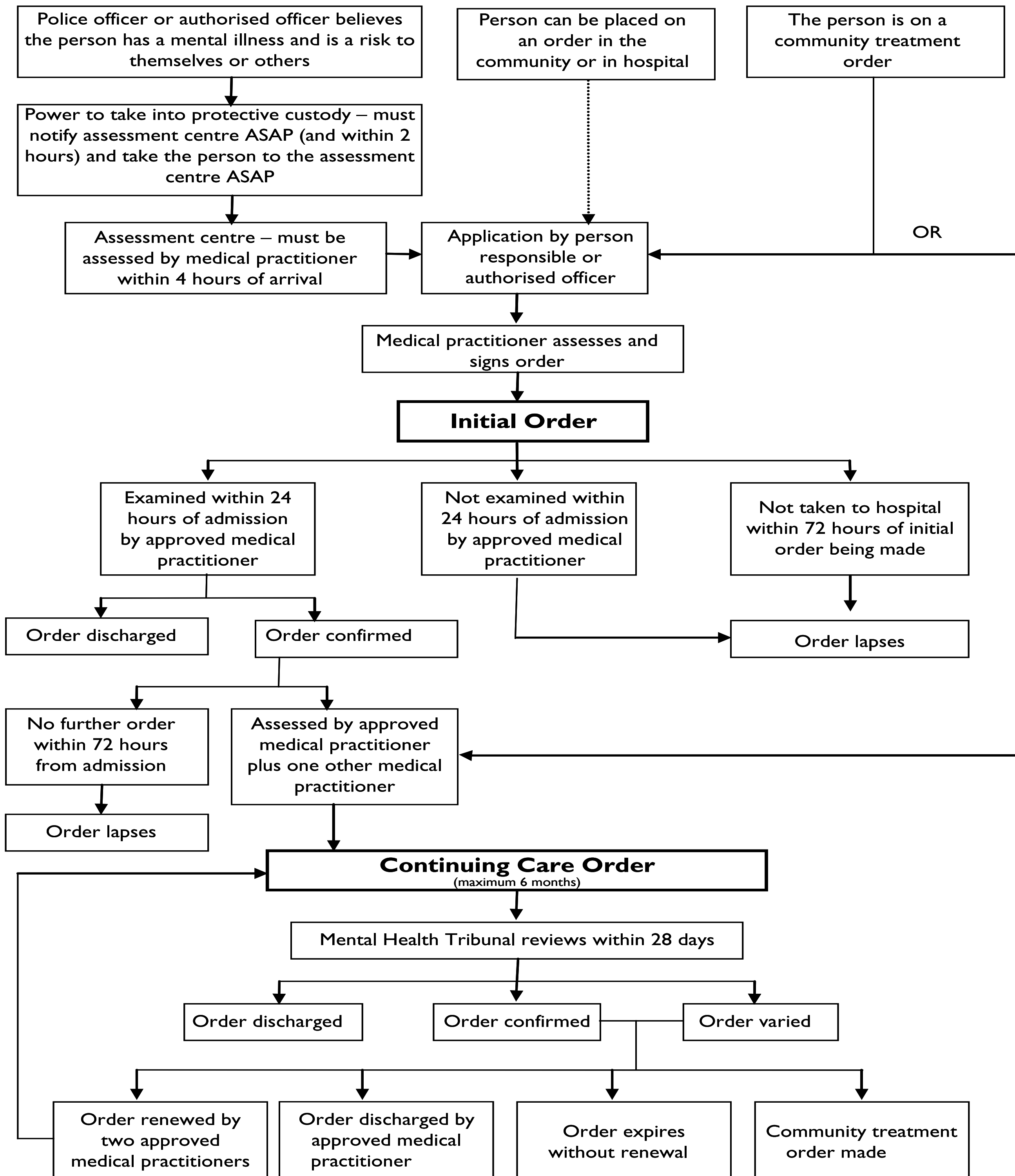
An Initial Order enables a person to be involuntarily detained in an approved hospital for up to 24 hours, and such an Order may be extended for up to a further 72 hours if it is confirmed by an approved medical practitioner.

An Initial Order may be made while the person to whom it applies is in the community or in hospital; in the event that the person is in the community at the time that the Order is made it is also authority for the person to be taken into protective custody and taken to an approved hospital to be detained therein. The Order is authority for this to occur for up to 72 hours after it is first made.

Continuing Care Orders last for up to six months and may be renewed for subsequent periods of six months by two approved medical practitioners.

A person must be subject to either an Initial Order or a Community Treatment Order, before a Continuing Care Order may be made.

Mental Health Act 1996
Involuntary Detention Pathway



Community Treatment (Sections 40 – 44C)

A person in the community may be required to take, or submit to the administration of treatment; to attend at a specified place in order to receive treatment; or to comply with certain other specified requirements, by way of a Community Treatment Order.

A person may be placed on a Community Treatment Order by two approved medical practitioners if each of the practitioners considers that the criteria for making a Community Treatment Order are met.

The criteria for making a Community Treatment Order are that:

- the person has a mental illness; and
- there is, in consequence, a significant risk of harm to the person or others unless the mental illness is treated; and
- the order is necessary to ensure that the illness is properly treated; and
- facilities or services are available for the care and treatment of the person.

Community Treatment Orders last for up to 12 months and may be renewed for subsequent periods of 12 months by two approved medical practitioners.

A person who fails to comply with the requirements of a Community Treatment Order may be admitted to an approved hospital as an involuntary patient. Specifically, an approved medical practitioner may authorise the temporary admission of a person who is on a Community Treatment Order to an approved hospital if both the practitioner and either an authorised officer, a medical practitioner or the person responsible for the patient are satisfied that:

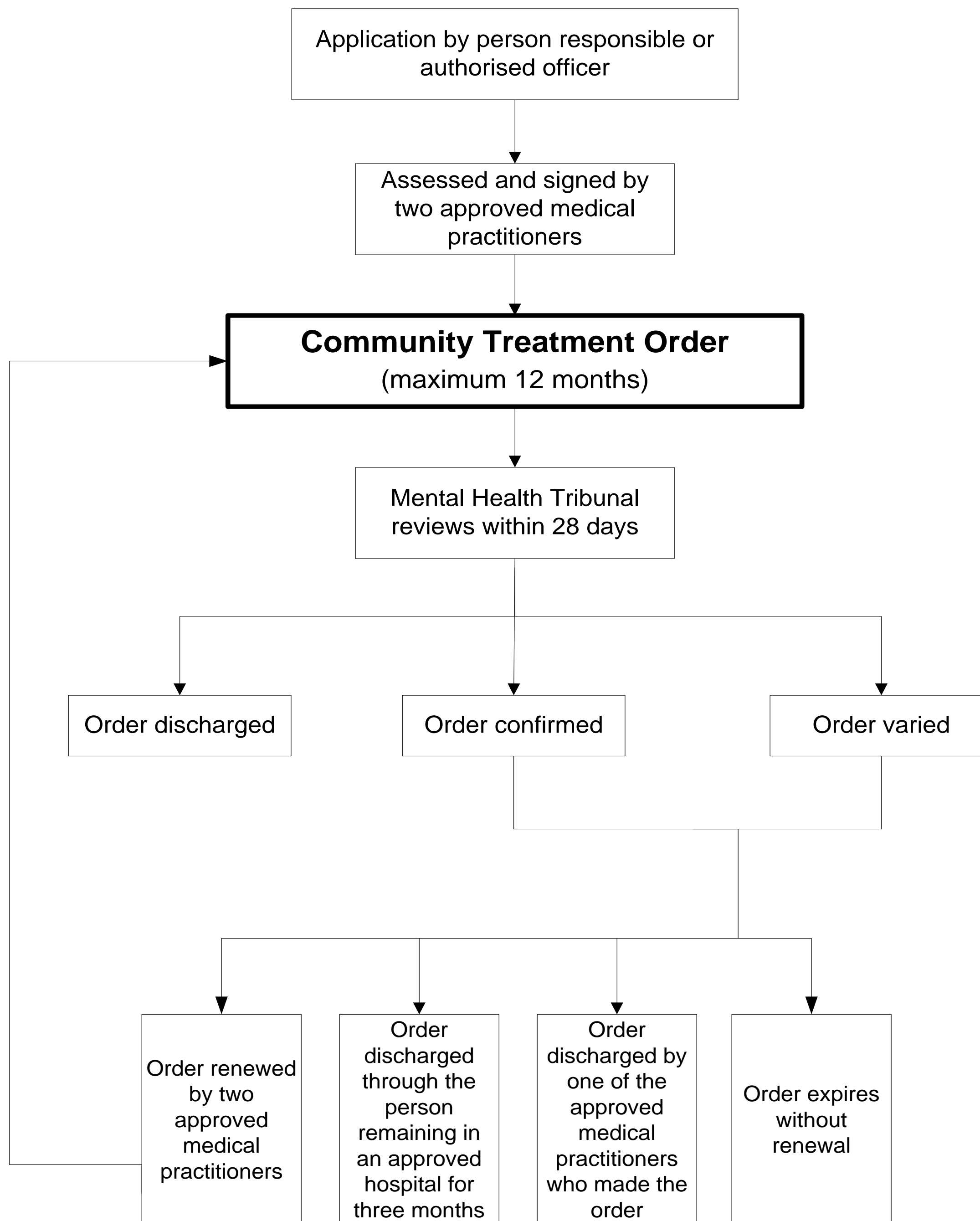
- the patient has failed to comply with the order, and
- all reasonable steps have been taken to obtain the patient's cooperation in complying with the order; and
- the patient's health has deteriorated, or there is a significant risk of this occurring, because of the patient's failure to comply with the order.

An authorisation for temporary admission is authority for the person to whom it applies to be taken into protective custody and detained in an approved hospital for up to 14 days. During this time the Community Treatment Order is suspended.

Following an authorisation for temporary admission, the person may either be returned to the community at which point the Community Treatment Order would continue, or placed on a Continuing Care Order requiring the person's continued detention in an approved hospital.

Mental Health Act 1996

Community treatment order



Hospital-Based Treatment Pathway (sections 31 and 32)

Pursuant to section 31 of the *Mental Health Act* medical treatment may be administered to a patient who is in an approved hospital:

- with the patient's informed consent; or
- if the treatment is authorised by or under the *Guardianship and Administration Act 1995*.

Section 32 of the *Mental Health Act* enables medical treatment to be given to a patient who is in an approved hospital notwithstanding the absence or refusal of consent to treatment if an Order to this effect is made by the Guardianship and Administration Board. The Board must however be satisfied that:

- a person has a mental illness that is amenable to medical treatment; and
- a medical practitioner has recommended medical treatment for the illness but the person has refused or failed, or is likely to refuse or fail, to undergo the treatment; and

the person should be given the treatment in his or her own interests or for the protection of others.

Given the lack of decision making capacity experienced by many involuntary patients who are being detained in an approved hospital pursuant to the *Mental Health Act* authority for treatment by or under the *Guardianship and Administration Act* is the most common route by which authority for treatment is sought.

The *Guardianship and Administration Act* enables substitute consent to treatment to be given for a person who because of a disability lacks the capacity to provide his or her own informed consent to the treatment either:

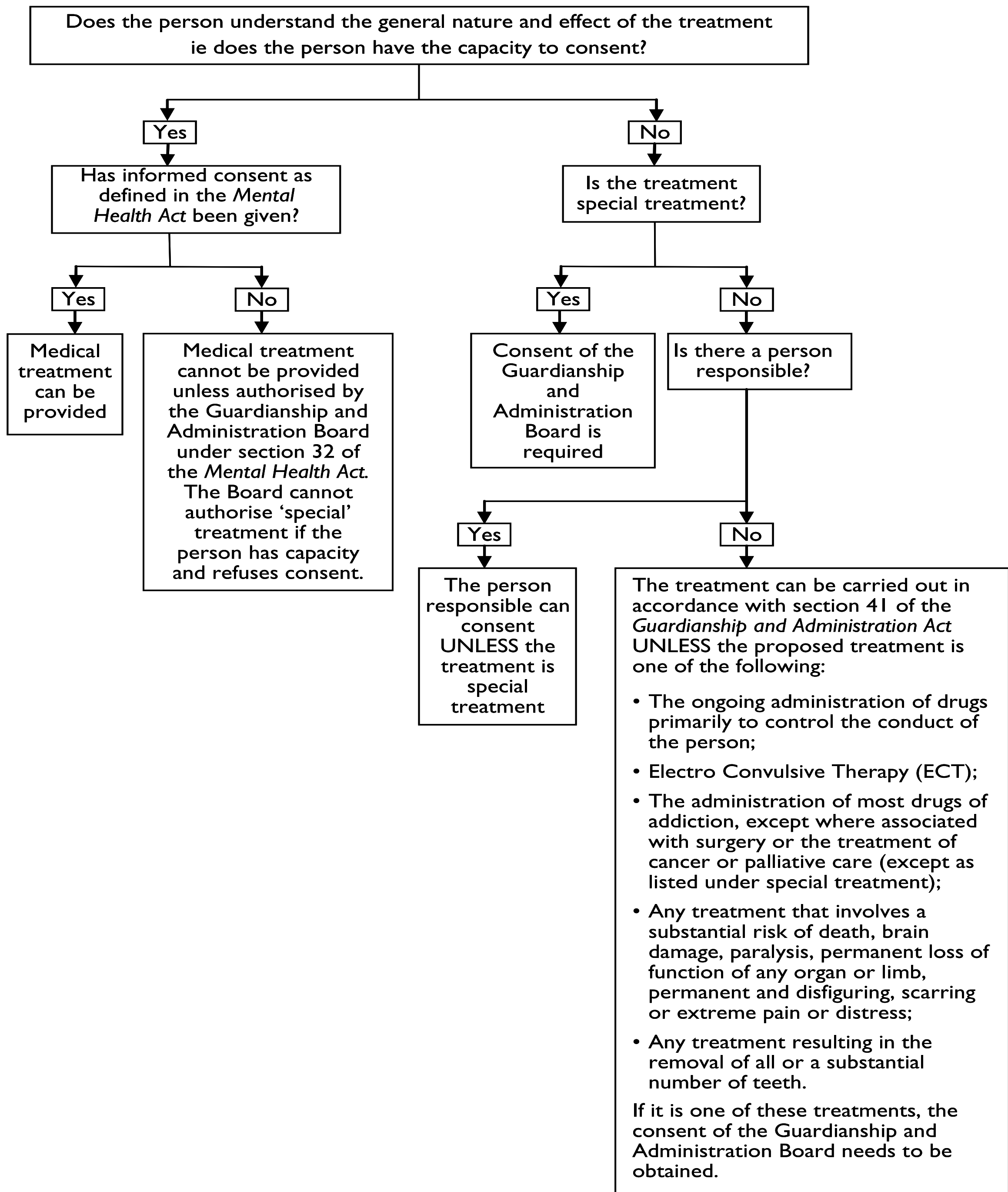
- by a person responsible including a guardian appointed pursuant to the *Guardianship and Administration Act*. In practice, this is the most common way by which treatment is authorised for persons lacking capacity; or
- by the Guardianship and Administration Board, where there is no person responsible, and where the treatment is in the best interests of that person.

Who may be a person responsible for another person is set out in section 4 of the *Guardianship and Administration Act* as being:

- where the other person is under the age of 18 years and has a spouse, the spouse; or
- where the other person is under the age of 18 years and has no spouse, his or her parent; or
- where the other person is of or over the age of 18 years, one of the following persons, in order of priority:
    - his or her guardian;
    - his or her spouse;
    - the person having the care of the other person [within the meaning of section 4 of the *Guardianship and Administration Act*];
    - a close friend or relative of the other person.

The *Guardianship and Administration Act* also enables emergency psychiatric treatment to be given to a person with a disability without the need for consent where a medical practitioner considers the treatment to be necessary, as a matter of urgency, to save the person's life, or prevent serious damage to the person's health, or to prevent the person from suffering or continuing to suffer significant pain or distress.

Mental Health Act 1996
Consent to psychiatric medical treatment



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