

# Review of the Mental Health Act 1996 Issues Paper

Department of Health and Human Services



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## Foreword

### Invitation to comment

This issues paper has been prepared to assist individuals or organisations that wish to contribute information to the review of the *Mental Health Act 1996*. It provides readers with an overview of the legislation, poses key questions that may be addressed through written submissions and provides an opportunity for interested people to submit relevant information to the review.

An outcome of this phase of the review will be a set of options for legislative change to ensure that the Mental Health legislation in Tasmania promotes a model of care for mental health that is centred on people affected by mental illness, that promotes their recovery and that is provided equitably and efficiently.

The options developed from the review will be the subject of further discussion with stakeholders before final recommendations are prepared and submitted to the State Government for approval.

You are encouraged to participate in the review, to assist in the task of refining the legislation and to identify solutions to any problems in the present legislation.

Please note that:

- **You do not have to respond to every question in the Issues Paper, you may select just those questions that are of interest to you and respond to those.**
- **The issues paper does not prevent you from raising other issues that may not be mentioned in the paper, as long as they relate to the legislation and its operation.**
- You are invited to use the enclosed proforma for your written response. An electronic copy of this is available by following the links at [www.dhhs.tas.gov.au](http://www.dhhs.tas.gov.au) . You do not need to use this proforma for your response, but please ensure that you have included the relevant question number(s) in your response.

If you are unable to make a written submission and would like to make comment in other ways, please come along to one of our stakeholder or community forums. If you cannot attend one of the forums, please contact Patricia Barron on (03) 62307028 to determine how your information may best be provided.

## Written submissions

You can send written submissions to:

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If you have further inquiries, telephone:

Patricia Barron  
Tel: (03) 6230 7028  
Fax: (03) 6230 7739

## Forums

*If you would like to attend one of these forums, please contact Patricia Barron on 6230 7028.*

### Public Forum details:

#### Launceston

Wed 9 <sup>th</sup> May	2:30pm – 4:30pm	Mercure Hotel
Wed 9 <sup>th</sup> May	7:00pm – 9:00pm	Mercure Hotel

#### Burnie & Devonport

Tues 15 <sup>th</sup> May	7:00pm – 9:00pm	Burnie Civic Centre
Wed 16 <sup>th</sup> May	3:30pm – 5:30pm	Devonport Entertainment & Convention Centre

#### Hobart

Tues 22 <sup>nd</sup> May	7:00pm – 9:00pm	Mercure Hotel
Wed 23 <sup>rd</sup> May	1:30pm – 3:30pm	Mercure Hotel

**Stakeholder Forum Details:****Launceston**

Thurs 10 <sup>th</sup> May	9:00am – 10:30am	Non-Government Organisations Forum	Mercure Hotel
Thurs 10 <sup>th</sup> May	11:30am – 1:00pm	Consumer Forum	Mercure Hotel
Thurs 10 <sup>th</sup> May	2:30pm – 4:00pm	Carer Forum	Mercure Hotel

**North-West**

Tues 15 <sup>th</sup> May	3:00pm – 4:30pm	Consumer Forum	Burnie Civic Centre
Wed 16 <sup>th</sup> May	9:30am – 11:00am	Carer Forum	Ulverstone Civic Centre
Wed 16 <sup>th</sup> May	12:30pm – 2:00pm	Non-Government Organisations Forum	Ulverstone Civic Centre
Thur 17 <sup>th</sup> May	10:00am - 11:30am	Consumer Forum	Devonport Entertainment & Convention Centre

**Hobart**

Tues 22 <sup>nd</sup> May	10:00am - 11:30am	Carer Forum	Mercure Hotel
Tues 22 <sup>nd</sup> May	1:00pm – 2:30pm	Consumer Forum	Mercure Hotel
Wed 23 <sup>rd</sup> May	10:00am - 11:30am	Non-Government Organisations Forum	Mercure Hotel

**Venue Addresses:**

Launceston	Mercure Hotel	3 Earl St Launceston
Burnie	Burnie Civic Centre	Wilmot St Burnie
Ulverstone	Ulverstone Civic Centre	Patrick St Ulverstone
Devonport	Devonport Entertainment & Convention Centre	Rooke St Devonport
Hobart	Mercure Hotel	156 Bathurst St Hobart

## Background to the Review

The *Mental Health Act 1996* brought about a number of changes to the way in which mental health services were delivered and reviewed. It was the intention of the Act to bring Tasmanian legislation into line with national and international principles and standards in mental health.

The Act had a long gestation period: it was the result of well over 10 years' work in drafting and implementing the legislation, with consultation at each phase. The Act was passed in 1996 but proclamation was delayed until November 1999, which allowed for development of policy and procedures and for these to be fully implemented ready for proclamation. This process allowed for a smooth and relatively quick transition to the new model.

At the time the Act was implemented, the stated intention was to review its operation following a 12-month settling-in period. The purposes of that review were to ensure that the Act facilitated effective practice, and to identify any need for further changes.

In November 2000, the President of the Mental Health Tribunal raised two issues that she said needed immediate attention: the inconsistency of being able to detain people against their will but not treat them against their will under the *Mental Health Act 1996*, and the non-enforceability of community treatment orders.

Other issues of concern about the operation of the Act have been raised at various times by clinicians, mental health workers, people with mental illness, carers and various organisations. This Review will draw on the experience of workers, carers, people with mental illness and practitioners involved in mental health services since the implementation of the new legislation in 1999.

An amendment to the Mental Health Act was made in early 2005 to address the issue of non-enforceability of community treatment orders. The amendment (which commenced in July 2005) has a three-year 'sunset clause' ending in June 2008.

The Mental Health Services Strategic Plan for 2006 to 2011 identifies a number of key strategies with 'an emphasis on providing services that are recovery focused, based in environments providing the least restrictive care and involve working in partnership with others'. The Strategic Plan was developed after broad and exhaustive community and stakeholder consultation. The outcomes of this Review of the Mental Health Act will need to be consistent with the principles

developed in the strategic planning process and must support the strategic direction.

Consistent with the mood for change prompted by the Strategic Plan, the Minister for Health and Human Services requires that, should this review recommend changes to the Act and/or related legislation, those changes must be ready for consideration by State Parliament in the first half of 2008. This is consistent with the intention that, if approved by Parliament, the changes can be proclaimed before the July 2005 amendments lapse due to the 'sunset clause'.

Major amendments to the Act were implemented in February 2006 to facilitate the operation of the Wilfred Lopes Centre for Forensic Mental Health. These new provisions will be treated as related legislation in this Review.

Legislative reform of this nature is a balancing act of sometimes competing interests, such as risk to others and the right to choose, civil liberties and the need to detain. These are ethical issues and not easily resolved in legislation; nonetheless, they are part of the environment in which this Review will progress.

## Overview of the legislation

The Mental Health Act brought about a number of changes to the way in which mental health services are delivered and reviewed. This chapter explains the foundations of the Act and provides a summary of its key features, including voluntary and involuntary hospital admission; medical and non-medical treatment and care in hospitals; community treatment orders; and the roles of the Mental Health Tribunal and official visitors.

The Mental Health Act and related legislation can be viewed in full at [www.thelaw.tas.gov.au](http://www.thelaw.tas.gov.au)

## Background

The Mental Health Act brought Tasmanian legislation into line with national and international standards in mental health, and was drafted following extensive community consultation. The legislation reflected modern approaches to the care of people who have a mental illness. The philosophy underlying the Act was drawn from both national and international principles. The *National Mental Health Policy and Plan* and the United Nations *Principles on the Care and Protection of People with a Mental Illness and for the Improvement of Mental Health Care* provide valuable background information on the aims of the legislation.

### International human rights

The United Nations *Principles for the Protection of Persons with a Mental Illness and for the Improvement of Mental Health Care* were issued in 1991. These principles have provided the broad basis for the Tasmanian Mental Health Act. The objects (which outline the Act's objectives) of the Act (in sections 6 and 7) broadly reflect the UN principles, and the provisions in the Act were drafted with the UN principles as a guide.

### National policy and strategies

On the national level, one aim of the *National Mental Health Policy and Plan* was to ensure consistent legislation across Australia, an aim not yet achieved, but which should guide the current review. The Tasmanian Mental Health Act provided for agreements to be entered into with other states to allow the transfer of people on orders across state boundaries. These agreements have not yet been achieved. The

Act also drew from the *National Statement of Rights and Responsibilities* and the *Model Mental Health Clauses*.

The Mental Health Act helped Tasmania to meet national standards for mental health legislation, particularly in regard to the rights of people affected by mental disorders and/or mental health problems.

## **The Tasmanian legislative framework**

### ***Mental Health Act 1996***

This Act makes provision for the care and treatment of people with mental illnesses and for safeguarding their rights.

### ***Guardianship and Administration Act 1995***

The Guardianship and Administration Act established the Guardianship and Administration Board. The Board deals with financial and lifestyle matters for people with disabilities that affect their ability to make decisions. There are special provisions under the Mental Health Act for applying to the Guardianship and Administration Board for consent to medical treatment for a person with a mental illness.

### ***Criminal Justice (Mental Impairment) Act 1999***

This Act makes provision for the detention and treatment of people who are unfit to be tried and people found not guilty of a crime by reason of insanity. The Act also deals with the release of such persons.

### ***Sentencing Act 1997***

Under this Act, people who are found guilty of offences may become subject to orders under Mental Health legislation.

## **The foundations of the Mental Health Act**

The foundations for the Mental Health Act are established in its first few sections, where the following may be found:

- the definitions used in the Act (section 3);
- the definition of mental illness (section 4);
- the concept of the 'person responsible' (section 5);

- the objects of the legislation (section 6);
- the principle of minimum interference with a person's rights (section 7).

### **Interpretation – section 3**

Section 3 of the Act defines the key terms and concepts. As a general rule, bodies or positions (such as 'approved medical practitioner') are defined in this section. Other words in the Act that may have an expanded meaning, such as 'seclusion', 'restraint', 'harm' and 'spouse', are also defined in this section. If a word is not defined, then in general, the ordinary, commonsense meaning applies.

### **The definition of mental illness – section 4**

To use the powers in the Act that relate to involuntary admission to hospitals, the initial question is whether the person has or appears to have a mental illness as defined in section 4. This is the preliminary question that must be answered by all practitioners because it establishes the authority to use powers conferred by the legislation.

Under the Mental Health Act, a mental illness is defined as a mental condition resulting in:

- serious distortion of perception or thought; or
- serious impairment or disturbance of the capacity for rational thought; or
- serious mood disorder; or
- involuntary behaviour or serious impairment of the capacity to control behaviour.

The Act also specifies that a diagnosis of mental illness may not be based solely on a person's antisocial behaviour, their intellectual or behavioural nonconformity, their intellectual disability, or their intoxication by reason of alcohol or a drug.

It should be noted that the definition of mental illness is specific to the operation of the Act. It is not intended to define or prescribe service provision in the area of voluntary admission, which may well relate to a wider range of conditions such as mental disorder.

## **The person responsible – section 5**

The person responsible has a number of potentially important roles under the Mental Health Act, including the right to:

- apply for a person to be involuntarily admitted (s25)
- consent to medical treatment if the person lacks capacity to consent (s43 Guardianship and Administration Act).

If a person is admitted involuntarily, the person responsible must be given a statement of the admitted person's legal rights and information about their condition and proposed treatment.

The Act distinguishes between people who are under 18 and those over 18 in determining who is the person responsible, as follows:

- **People under 18**

If the person is under 18, the person responsible is her or his spouse, and if there is no spouse then the person's parent. If there is a care and protection order made for the person under the *Children, Young Persons and Their Families Act 1998*, the Secretary of the Department of Health and Human Services or other guardian listed in the order is taken to be the person responsible for him or her.

- **People 18 years and older**

If the person is 18 years or over, the Act gives a list of people who may be considered the person responsible. This list is in order of priority; that is, the person who is first on the list should be approached first and so on. The order of priority is as follows:

- The person's guardian. This is defined in section 3 as a person appointed as a guardian or an enduring guardian under the Guardianship and Administration Act.
- The person's spouse. This includes a 'de facto' spouse or same-sex partner. The spouse must have a close and continuing relationship with the person and cannot themselves be under guardianship.
- The person's carer, where the carer provides or arranges domestic services and support on a regular basis and is unpaid. Receiving a carer's pension is not considered to be receiving payment in this context. If the person lives in a hospital, nursing home or other residential facility and is cared for in the facility, the person who cares for them is not the person responsible, in the absence of other factors. In this situation, the person responsible may be the person

who provided care before the person moved to the hospital, nursing home or other facility.

- A close friend or relative, where there is both a close personal relationship through frequent personal contact and a personal interest in the person's welfare, on an unpaid basis.

### **The objects of the Act – section 6**

National and international standards are embodied in the objects of the legislation. Objects of legislation are principles which guide the interpretation of the Act. The legislation will be interpreted in a way that gives the greatest effect to the objects, and they are therefore the central guide to the Act. When there are two or more possible ways for a section in the Act to be interpreted, it is useful to go to the objects and see which interpretation best meets those objects.

The objects of the Act are both practical and aspirational. The practical objects can help decide the appropriate action in any given circumstance, and the aspirational objects provide a vision for the care we would like to see provided to all people with a mental illness.

The objects of the Act are:

- to provide for the care and treatment of people with mental illnesses in accordance with the best possible standards while at the same time safeguarding and maintaining their civil rights and identity; and
- to ensure that people detained involuntarily with mental illnesses are provided with appropriate information about their statutory and other rights; and
- to provide for the making and review of orders for involuntary admission, treatment and detention of people with mental illnesses; and
- to provide for the monitoring and review of the mental health system; and
- to ensure that the services provided for people with mental illnesses are equitable, comprehensive, coordinated, accessible and free from stigma, and in particular to ensure that standards of care and treatment for those people are at least equal to the standards of care and treatment for physical illnesses and disabilities; and
- to promote recognition in the community of the rights of people with mental illnesses to the best possible standards of care and treatment; and

- to reduce the adverse effects of mental illness on family life; and
- to encourage and contribute to the highest possible standards of:
  - (a) care and treatment for people with mental illnesses; and
  - (b) research into the cause of, and treatment for, mental illnesses; and
- to encourage the care and treatment of people with mental illnesses in the community, and to design and coordinate an integrated system of community support services for people with mental illnesses who are being cared for in the community.

### **The principle of minimum interference with civil rights – section 7**

Section 7 of the Act provides a clear direction to all people who use the Mental Health Act. It states that in exercising powers provided by the Act in relation to a person detained involuntarily, the following principles must be observed:

- restrictions on the liberty of the person and interference with the person's rights, dignity and self-respect must be kept to the minimum, consistent with the need to protect the person and others;
- effect must, if practicable, be given to the person's wishes so far as that is consistent with:
  - (a) the person's best interests; and
  - (b) the need to protect the person and others; and
  - (c) in the case of a person using forensic services, the good order and security of the secure mental health unit.

### **Voluntary admission**

Section 19 of the Mental Health Act defines voluntary admission as being admission to hospital with the person's consent, or with the consent of a parent or guardian if the person is under 14 years of age. If a person under 14 resists admission to the approved hospital, they cannot be admitted as a person admitted voluntarily and consideration must be given to the use of an involuntary order.

### **Refusal of admission and second opinions – sections 20 and 21**

If a doctor refuses to admit a person as a person admitted voluntarily, they must tell the person why admission is refused and refer them to other facilities that may be appropriate.

Provision is made in the Act for a second opinion if a person is refused admission on the grounds that they do not have a mental illness which can be treated at the hospital (section 21). In these circumstances, the person must be referred to an approved medical practitioner, who can confirm the order not to admit the person or may request that the person be admitted.

### **Discharge from hospital – sections 22 and 23**

The right of a person admitted voluntarily to discharge himself or herself at any time is stated in section 22. If a person admitted voluntarily seeks to discharge himself or herself from hospital, a medical practitioner or an approved nurse may detain the person for up to four hours, to allow for the examination of the person and to have a decision made about whether an order should be made for the involuntary hospitalisation of the person (section 23).

### **Involuntary admission**

The Act creates two main orders that allow for involuntary hospitalisation – an initial order and a continuing care order. Before these can be made, an application by a person responsible or an authorised officer is required. (Recent amendments also allow for involuntary admission using an authorised temporary admission for a person on a community treatment order – these are explained later.)

### **The criteria for detention as a person admitted involuntarily – section 24**

A person can only be placed on an initial order or a continuing care order if they meet the criteria for detention as a person admitted involuntarily. That is:

- 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 a person admitted involuntarily 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.

### **Initial orders – sections 24–27**

An initial order allows for involuntary admission for up to 72 hours. However, the person must be released after 24 hours if an approved medical practitioner has not examined them and confirmed the order during that time.

### **Continuing care orders – sections 28–30**

A continuing care order allows for involuntary admission to an approved hospital for up to six months and can be made if the person is already on an initial order or a community treatment order or an authorised temporary admission.

Before making an order for involuntary hospital admission, the treating team must consider what form of treatment will be the least restrictive alternative (see the objects and principles underpinning the Act, pages 14–15).

## **Medical treatment and care in hospital**

Under the Act, medical treatment can only be given with the person's informed consent, or if the treatment has been authorised under the Guardianship and Administration Act. Under the Guardianship and Administration Act, the person responsible may provide consent for the person in some situations.

Section 32 allows for someone else to apply to the Guardianship and Administration Board for approval for medical treatment if the person is refusing the treatment.

### **Informed consent – section 33**

The Mental Health Act defines informed consent in section 33. Before a valid consent can be given, the medical practitioner must give the person a clear and full explanation of the treatment, the person must be able to understand the general nature and effect of the proposed treatment, and they must freely and voluntarily consent.

## **Non-medical treatment in hospital**

Part 6 of the Mental Health Act deals with the non-medical treatment of people admitted involuntarily in approved hospitals. Non-medical treatment includes the use of physical restraint and seclusion, leave of

absence, and transfers of people admitted involuntarily between approved hospitals.

### **Seclusion and bodily restraint – sections 34 and 35**

The criteria that must be satisfied before seclusion and restraint are allowed are set out in sections 34 and 35 of the Act. Instances of seclusion and restraint must be recorded and the senior approved medical practitioner must send a report to the Mental Health Tribunal every month.

### **Leave of absence – section 37**

People admitted involuntarily can be given leave of absence if the treating psychiatrist approves this. The person must be given a written statement of the terms and conditions on which the leave of absence has been approved. The person must also be given notice in writing if the leave is revoked. Section 38 provides for the return of the person to hospital if they become absent without leave or if they do not comply with the conditions of their leave

### **Transfer between hospitals – section 39**

A person admitted involuntarily may be transferred from one approved hospital to another if the transfer is necessary or desirable for the care or treatment of the person, or for the purpose of avoiding or minimising risk to others. The controlling authority of each hospital must agree before a transfer can take place.

## **Community treatment orders**

Community treatment orders provide a less restrictive alternative to hospital admission for people who still require involuntary treatment for their mental illness. A community treatment order can be made for up to 12 months and can require the person to attend appointments as an outpatient and/or to submit to treatment as decided by their treating doctor.

### **Criteria for making community treatment orders – section 40**

As with orders for involuntary hospitalisation, the Mental Health Act provides strict criteria that must be met before a community treatment order can be made. These 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.

### **Authorised Temporary Admission – section 44A**

A community treatment order does not in itself allow the person to be involuntarily hospitalised. An approved medical practitioner may authorise the temporary involuntary admission of a person to whom a community treatment order applies, if that practitioner and an authorised officer, another medical practitioner or the person responsible for the person are both satisfied that:

- the person has failed to comply with the order; and
- all reasonable steps have been taken to obtain the cooperation of the person in complying with the order; and
- the health of the person has deteriorated, or there is a significant risk that their health will deteriorate because of their failure to comply with the order.

If the person is hospitalised for less than three months, the community treatment order is suspended while they are in hospital and revives on discharge. If the person is hospitalised for over three months the order lapses and another community treatment order needs to be made.

### **Information requirements**

The Act states that people must be given a written statement of their legal rights when an order under the Act is made. This statement must also be given to their relative or carer who is the person responsible.

In addition, people must be given a statement of their diagnosis and treatment when this has been determined. There is an obligation to provide information in a way that the person can understand, if this is possible. If information is withheld from the person, the Mental Health Tribunal must be notified within 48 hours.

## **Review of involuntary orders**

### **The Role of the Mental Health Tribunal**

Under the Act, the Mental Health Tribunal must review continuing care orders and community treatment orders within 28 days of the order being made. The Tribunal can revoke, vary or confirm these orders. The Tribunal can also review orders, including authorised temporary admissions, on the application of either the person who is the subject of the order or a person who has an interest in their welfare.

The Tribunal also monitors and can issue guidelines for the regulation of:

- the use of seclusion in approved hospitals; and
- the use of restraint in approved hospitals.

On application the Tribunal also reviews:

- the withholding of information from a person or a person responsible; and
- decisions to transfer a person or to refuse to transfer a person under sections 39 and 72B of the Act.

### **Official visitors**

The Act introduced an official visitor scheme, following a recommendation in the *Burdekin Report*. Most other states and territories have an official visitor program in some form. The role of the official visitors is to visit mental health facilities and examine the physical environment and care of people with mental illness as well as to investigate suspected breaches of the Act and complaints.

The official visitors must visit approved hospitals at least once a month, and can require the senior approved medical practitioner to produce records relating to the admission, care and treatment of people, arrange interviews with people using mental health services, or answer questions about their care or treatment. Hospitals are required to inform the official visitors of any requests people have made to see them. Official visitors must report any suspected contravention of the Act to the Mental Health Tribunal.

## Summary of key issues

This chapter briefly describes some of the major issues that are facing mental health service-providers around the world. These are broad questions that extend beyond the individual sections of the Mental Health Act and related legislation.

At the heart of these questions is the ongoing problem of balancing the rights of people to make decisions about their own lives and not to be subjected to detention and medical treatment without their consent, with the need for treatment and care and the protection of themselves and others.

### An increasing international focus on rights

The *Mental Health Act 1996* brought Tasmania into line with national and international standards in mental health. It also reflected the considerable changes in social attitudes and legal approaches to providing services for people with a mental illness that had occurred in the years before the Act's development. In the decade since the Act was passed there have been further significant changes, both nationally and internationally, in approaches to providing mental health services. In particular, there has been further focus on upholding the rights of people using mental health services.

The worldwide human rights movement has brought about substantial changes in social attitudes and legal approaches to mental health care, treatment and protection in westernised and developed countries, and its influence is increasing. International and national human rights charters and conventions have confirmed the rights of the mentally ill, established acceptable standards of care and treatment, and imposed stringent legal, procedural safeguards for people forcibly detained and treated.

In Europe, the influence of the European Convention on Human Rights is considerable, and incorporating the decisions of courts such as the European Court of Human Rights into law and government policy is obligatory on member countries, including the United Kingdom, which enacted the *Human Rights Act* in 1998. The *Charter of Rights and Freedoms* (1982) has been profoundly influential in shaping mental health law in Canada. In Australia, the Australian Capital Territory and Victoria now have charters of human rights, and Tasmania and Western Australia are in the process of reviewing the introduction of human rights charters. It is likely that all Australian states will have enacted a human rights charter within a decade.

An important principle in human rights law is reciprocity. The right of a government to make laws that force care and treatment on a mentally ill citizen places a legal obligation on the government to reduce the necessity to apply such force by providing the citizen with access to sufficient, quality services to keep them well and safe in the community.

Key mental health and rights related issues that are being discussed internationally and in Tasmania include:

- The extent to which services are able to detain and treat people without their consent. Tasmanian law provides for detention without consent but not effectively for treatment without consent, and does not provide for a right to treatment once someone has been detained.
- The extent to which detention and treatment without consent assist or hinder the recovery of the person.
- The safeguards that are required to protect people's rights if detention and treatment without consent are allowed.
- The level and type of services that should be provided to reduce the need for detention and treatment without consent.
- The principles and procedures relevant to deciding whether treatment without consent is in the best interests of the person, and what these best interests are.
- The effectiveness of the mechanisms for reviewing decisions to detain and treat without consent and the representation that people should receive when these decisions are being reviewed.

There are opportunities to respond to some of these broader issues below.

## **General questions relating to the Mental Health Act**

In order to stimulate discussion, this issues paper puts forward many questions that are likely to have a bearing on any revisions to the Tasmanian Act. These initial questions are not intended to be exclusive: others may well be raised, both by health professionals and members of the public. But the questions brought forward here should, at the very least, provide starting points for informed discussion.

The questions are numbered (1–59) for ease of reference during discussions. For convenience, they are mostly grouped under particular aspects of the Tasmanian *Mental Health Act 1996*.

- 1) *What are your views in relation to adding the ability to treat without consent to the ability to detain in the Mental Health Act?***
- 2) *Are the current review mechanisms in the Act adequate to protect the rights and promote the best interests of people with a mental illness? If so, Why? If not, Why not?***
- 3) *What are your views on the current safeguards for people's rights in the Act? Are any additional safeguards required?***
- 4) *Should the Act provide any specific requirements to ensure that people of culturally and linguistically diverse backgrounds are not discriminated against? If so, what type of requirements?***

## Issues relating to specific provisions

### Part 1 – Preliminary

#### Section 4 – Definition of mental illness

Legal definitions of mental illness vary extremely widely and no two Australian jurisdictions use the same terms. The definition in the Act is, however broadly similar to many to be found elsewhere.

Some of the problems with the definition in the Mental Health Act are:

- the difficulty that arises from the exclusions in section 4(2), particularly 'intoxication by reason of alcohol or drug'. A person may appear at a hospital in an intoxicated state but may also have a mental illness which it is not possible to assess for some time;
- the definition being readily applicable to other illnesses not usually considered mental illnesses, such as dementia or acquired brain injury.

#### **5) *The current definition of mental illness in the Act is:***

*a mental condition resulting in:*

- *serious distortion of perception or thought; or*
- *serious impairment or disturbance of the capacity for rational thought; or*
- *serious mood disorder; or*
- *involuntary behaviour or serious impairment of the capacity to control behaviour.*

#### ***The Act specifies that:***

*a diagnosis of mental illness may not be based solely on –*

- *antisocial behaviour; or*
- *intellectual or behavioural nonconformity; or*
- *intellectual disability; or*
- *intoxication by reason of alcohol or a drug.*

***What are your views on this definition? Are there any changes you would recommend?***

## **Section 5 – The role of the person responsible**

Some concerns have been expressed that the current role of the ‘person responsible’ described in the Act places undue pressure on the person responsible and can harm the relationship between them and the mentally ill person (especially when the person responsible has consented to medical treatment which the mentally ill person later objects to). A large proportion of the applications received by the Guardianship and Administration Board are made after the person responsible has expressed to the medical practitioner that they do not feel they can consent to treatment because it would harm their relationship with the mentally ill person.

A second concern is that it is difficult to establish who the person responsible is, if someone’s episode of mental illness makes them uncooperative with or disconnected from their potential person(s) responsible.

**6) *Are there any changes that you would recommend to the role or definition of the “person responsible” in the Act?***

***See also questions 41–42 relating to the person responsible and the right to information for people admitted involuntarily.***

## **Section 5AA – Informed consent**

There is no requirement in the legislation to document a patient’s consent to medical treatment. The presumption is that consent has been given to the medical practitioner at the time of prescribing the treatment.

**7) *How can we ensure that clinicians are addressing the criteria in section 5AA of the Mental Health Act when seeking consent for proposed treatment?***

**Section 6 – Objects of the Act, and Section 7 – Principle of minimum interference with civil rights**

(see pages 13,14 for an outline of these objects & principles)

The human rights approach of the present Act is consistent with very widespread international developments in mental health legislation over the last third of the 20th century, particularly since the mid-1980s. Internationally, the prominence of rights considerations in mental health continues to grow rather than decline.

The principles in the Tasmanian Mental Health Act relating to a person's rights are limited, as indicated by the section heading. In other jurisdictions considerably more principles are espoused in the legislation. For instance the Victorian legislation includes 10 principles related to treatment and care and the Queensland legislation has a series of principles relating to a broad range of rights, including the need to respect the person as a member of broader communities. (See page 42 for links to mental health legislation in other states.)

- 8) *Are the principles developed through the consultation process for the Mental Health Services Strategic Plan adequately reflected in the objects and principles in the Act? If not, what amendments would you recommend?***

***(See Appendix 1 for the Service Principles of the Strategic Plan.)***

## **Part 2 – Administration**

### **Division 1 – Approval of hospitals and assessment centres (sections 9–11)**

The Ministerial approval process includes an assessment of whether the hospital or assessment centre is properly staffed and equipped to carry out care and treatment.

- 9) *Is there a need for the Mental Health Act to specify criteria for approved hospitals and assessment centres? If so, why? If not, why not?***

### **Division 1A – Chief Forensic Psychiatrist (sections 11A–11C)**

As part of the amendments to the Mental Health Act for the creation of a secure mental health unit, a statutory position of Chief Forensic Psychiatrist was created. The role of Chief Forensic Psychiatrist includes a power to make standing orders for the good management of secure mental health facilities, the responsibility of reporting on the quality of the forensic service, and also more practical functions such as authorising detention and treatment for forensic patients in certain urgent circumstances.

There may be a role for a similar position for general mental health services.

- 10) *Should the position of Chief Psychiatrist be created? If so what functions would this position have and who would the Chief Psychiatrist report to?***
- 11) *Should some of the report-receiving functions currently carried out by the Mental Health Tribunal be undertaken by a Chief Psychiatrist? If so, why, and which ones? If not, why not?***
- 12) *Should some or all of the functions of approved medical practitioners be transferred to a Chief Psychiatrist? If so, why? If not, why not?***

***(See also Part 5 – Medical treatment of people in approved hospitals, in relation to emergency treatment powers.)***

## **Division 2 – Approval of medical practitioners and authorised officers (sections 12–13)**

Currently there are no criteria for the approval of medical practitioners and authorised officers and there is no requirement that they receive training in relation to the relevant legislation.

The Act requires ministerial approval for these appointments; however, in the more recent amendments relating to secure mental health units, similar functions have been assigned to the Secretary of the Department.

**13) *Is there a need for criteria for the approval of medical practitioners and authorised officers to be included in the Mental Health Act? If so, what should the criteria be?***

**14) *Should the criteria referred to in Question 13 include training in the relevant legislation?***

## **Part 3 – Power to deal with person with a mental illness**

### **Section 15 – Power to take person into protective custody**

This power provides an opportunity for authorised officers to take at-risk people to an assessment centre and for the initial assessment of the person without the strict application of the criteria for an initial order. It also provides a time limit on this process, to protect the person's rights. The provisions relating to protective custody, however, are not consistent throughout the Act. A specific issue raised is that authorised officers need clarity about their authority under sections 15(2) and 15(3) in any situation where they are taking a person into protective custody, not just under 15(1). Sections 15(2) and 15(3) allow an authorised officer to enter premises without a warrant, to be accompanied by a Police Officer and to use reasonable force. Some of the terminology also needs to be made more consistent.

**15) *Does protective custody work in the way that the Mental Health Act intends? If so, how? If not, why not?***

**16) *Are there sufficient protections in the Act for the individual's rights in relation to protective custody? If not, what should be added?***

**17) *Who should be authorised officers for the purpose of protective custody? What roles should Police, ambulance officers and clinicians play?***

- 18) *Should the power to enter premises to take someone into protective custody require a form of approval to enter? If so, what form should this approval take? If not, why not?***

#### **Part 4 – Admission to approved hospitals**

Considerable confusion exists between the provisions of the Guardianship and Administration Act and the Mental Health Act with respect to the voluntary admission. If the Guardianship and Administration Board has decided that someone does not have capacity and appoints a guardian, and the guardian decides that the person must stay in hospital, it is not clear whether the admission is voluntary or involuntary.

- 19) *If a Guardianship Order or Enduring Guardian has been appointed, should the person be considered a voluntary admission or an involuntary admission? Please explain the reasons for your answer.***

#### **Section 20 – Refusal of admission, and section 21 – Second opinion on refusal of admission**

There are concerns raised regularly about people being inappropriately refused admission and the difficulty they face in getting second opinions. An issue reported is that even though priority in the legislation is given to encouraging voluntary admission, beds are not available due to the number of involuntary admissions.

It is reported that even though the strict criteria of the continuing care order and the actual definition of mental illness do not apply to this type of admission, they are being applied as a filter in assessing admission.

Records of refusals of admission are not being kept, so this is not an issue that official visitors or anyone else can monitor effectively.

- 20) *How can the emphasis on voluntary admission be strengthened and confidence in the process maintained?***

### **Division 3 – Involuntary admission**

It appears that the basic structure of the provisions of Division 3 is effective, but that there is a lack of clarity about the timing of involuntary admissions and orders. There is uncertainty about when they start and therefore when they terminate.

Significant concerns exist regarding the criteria for involuntary admission. Specifically:

- as mentioned previously in this paper, the exclusions that form part of the definition of mental illness have allowed people who present in intoxicated states to be denied admission despite the fact that they may require admission on the basis of a mental illness;
- the Act does not define the word ‘significant’ in section 24(b) (in the context of ‘a significant risk of harm ...’) and therefore there is inconsistent application of the term;
- the definition of harm in the Act provides no help over what may be considered in deciding ‘risk of harm’;
- there is no opportunity to observe and assess the person prior to the application of the criteria (that is, the criteria for an initial order are the same as for a continuing care order);
- there are no criteria relating to the person’s capacity to give consent to involuntary admission;
- the legislation gives equal weight to risk of harm to self and risk of harm to others.

There is no current requirement for the reporting of initial orders. This has meant that there is no monitoring of how many initial orders are being made and in what circumstances.

- 21) *How can the start and finish time of initial orders be clarified?***
- 22) *Would a better definition of admission/discharge, or use of other terms not in general use in hospitals, improve the understanding of the timing of orders? If so, in what ways? If not, why not? (For example, should specific terminology be used for the orders, such as initiated/continued and revoked?)***
- 23) *Are there any additional criteria that should be included in relation to involuntary admission?***
- 24) *Is there a need for monitoring and review of initial orders, and if so, who should conduct this role?***

## **Part 5 – Medical treatment of people in approved hospitals**

Currently, the Act is constructed around involuntary detention. Treatment is not considered as a part of this detention. The vast majority of applications for involuntary treatment have been made under the Guardianship and Administration Act, which can only be used for people who are so mentally ill that they lack the capacity to consent.

The Guardianship and Administration Act does not cover people who have validly refused to consent to treatment but who should be provided with treatment in their own interests or for the protection of others. This situation is covered under section 32 of the Mental Health Act, but for a variety of reasons, traditionally it hasn't been used. The main obstacle to the use of section 32 is that it only applies to treatment in an approved hospital, whereas the Guardianship and Administration Act provisions can create an order that remains valid after discharge.

The current Act provides no right to treatment once a person has been detained. Many clinicians and carers argue that if you are going to detain someone against their will for a mental illness, you are morally obliged to treat the illness so that the person can be discharged. This debate has been raging in jurisdictions around the world for many years. If the Act is to be changed to include the right to treatment, then the objects of the Act will need to be altered, as will its structure and emphasis.

Similar issues apply to the treatment of people admitted voluntarily and to people in the community under community treatment orders. The amendments made to the Mental Health Act in 2005 have resulted in greater use of community treatment orders, but some practitioners believe that threatening people with hospitalisation so that they will consent to treatment is not good practice.

An issue that is often raised, particularly by practitioners, is that two review bodies (the Mental Health Tribunal and the Guardianship and Administration Board) and two Acts are involved in involuntary detention and involuntary treatment. This matter was raised during the drafting of the secure mental health unit legislation and a separate tribunal with jurisdiction over both areas was created in the Mental Health Act, resulting in an inconsistency in the legislation (see Part 10B of the Mental Health Act).

In urgent circumstances the Chief Forensic Psychiatrist may approve treatment for people in the secure mental health unit for an initial period of up to 96 hours. The same power does not exist for people using other mental health services. A member of the Forensic Tribunal may

give interim approval of treatment until the next hearing of the Tribunal. (See Sections 72H, 72I and 72J of the Mental Health Act).

**See Question 1) in relation to involuntary treatment - that also relates to this section.**

- 25) The Act provides (in section 32) that the Guardianship and Administration Board may give authority for a person to be treated without their consent if the treatment is in the best interests of the person. Should the Act more clearly define how to determine the best interests of the person? If so, in what ways? If not, why not?**
- 26) Should the one review body deal with the issues of treatment and detention? If so, why? If not, why not?**
- 27) Should the one order deal with both treatment and detention? If so, why? If not, why not?**
- 28) Should we streamline the process so that one order covers all circumstances, both hospital and community? If so, how?**
- 29) Should the role of a Chief Psychiatrist be created with similar powers to those of the Chief Forensic Psychiatrist for treatment in urgent circumstances? If so, why? If not, why not?**
- 30) If treatment is included in mental health orders, what model should be used?**
- 31) Should the provisions relating to tribunals and treatment be consistent between the civil and forensic parts of the Act? If so, why? If not, why not?**

## **Part 6 – Non-medical treatment of involuntary patients**

### **Division 1 – Restraint and seclusion**

The provisions of Part 6 only apply to people admitted involuntarily in an approved hospital. There are occasions when it may be necessary for restraint and seclusion to be used for a person admitted voluntarily, but there is no clear guidance given for this possibility. Generally, these cases are dealt with by placing the person on an involuntary order, which is contrary to the intention of the Mental Health Act.

Similarly, it may be necessary to restrain a person who is on a community treatment order, but this possibility is not provided for in the legislation.

An issue raised by people who use mental health services is that there is no immediate redress for them other than complaint at some point in the future. Notification of restraint and seclusion occurs monthly, and monitoring is at a systemic rather than an individual level.

- 32) *Should the restraint and seclusion provisions continue in their present form for people admitted involuntarily? If so, why? If not, why not, and how could they be amended?***
- 33) *Should these provisions be extended to people admitted voluntarily? If so, why? If not, why not?***
- 34) *Should the Act provide for the restraint of people on community treatment orders in certain circumstances? If so, why? If not, why not?***
- 35) *Should there be a mechanism to give people access to immediate review of decisions to restrain and seclude them? If so, why? If not, why not?***

### **Section 37 – Leave of absence**

These provisions require a leave of absence be notified to the Mental Health Tribunal every time the person is granted leave, including, for example, situations where the person is simply permitted to go for a short walk whilst accompanied.

- 36) *Is there a need to treat short leave differently from longer leave and, if so, how could this be done?***

### **Section 38 – Return of people admitted involuntarily to approved hospitals**

The provisions for a person to be returned to hospital for breaching leave conditions do not place an onus on the treatment team to take reasonable steps before making the return, nor is there provision for the person to have the return reviewed. This is inconsistent with the provisions created for authorised temporary admission under a community treatment order (see section 44A of the Mental Health Act).

- 37) *Should people returned to hospital due to an alleged breach of the conditions of a leave of absence have the same rights as those hospitalised for breaching an Authorised Temporary Admission? If so, why? If not, why not?***

## **Part 7 – Community treatment**

The authorised temporary admission amendments (which commenced in July 2005) have resulted in increased use of community treatment orders. Every jurisdiction, however, has struggled with legislating for community treatment, and the problems with involuntary treatment and community treatment orders remain. The increased use of community treatment orders has raised a number of questions about their operation:

- the enforcement of these orders by hospitalisation may have a negative effect on the person's recovery and is contrary to the intention of the legislation;
- authorised temporary admissions (section 44A of the Mental Health Act) are not reportable and therefore not monitored – a similar issue to the problem with initial orders;
- authorised temporary admissions can be for up to 14 days but are only reviewed if the person affected applies;
- the need for a community treatment order may be recognised by the practitioners in an approved hospital and an order created, but there is no requirement for the order to be actively implemented in the community, so the person may wait a considerable time for community follow-up;
- the medical practitioner creating the order is not the medical practitioner who later presents evidence for its continuance at the Tribunal, due to the handover of medical responsibility.

**38) *Are there ways in which it can be ensured that a person on a community treatment order receives treatment without the need for hospitalisation? If so, how? If not, why not?***

**39) *Authorised temporary admissions are subject to a sunset clause, and will cease at the end of June 2008. Should they be continued? If so, why? If not, why not?***

**40) *Is it possible to have a single category of order covering both hospital and community situations? If so, how could this be achieved?***

## **Part 8 – The right to information for people admitted involuntarily**

Issues that have been raised about the Act include the lack of information provided to carers and persons responsible.

- 41) *What rights to information should carers and persons responsible have?***
- 42) *Are there situations in which information should be shared with the person responsible against the wishes of the detained person? If so, what are these situations?***

## **Part 4 and Part 9 – the Mental Health Tribunal**

Recent amendments to the Act to set up the Forensic Tribunal have resulted in two tribunals in the legislation as well as referral of some matters to the Guardianship and Administration Board. Each of these bodies is different in nature and therefore has very different requirements. The process of appointment to the Forensic Tribunal is inconsistent with the process used for appointments to the Mental Health Tribunal and the Guardianship and Administration Board – and indeed for most other State tribunals.

A number of issues have been raised about the operation of the Mental Health Tribunal in the process of this review:

- The Act does not specify the make-up of Tribunal divisions (where the Tribunal sits with one or three members to decide a case). For instance, there is no requirement to have a legal and/or medical member on each division.
- There is no requirement for the Tribunal to provide reasons for its decisions.
- The Tribunal's reviews of continuing care orders and community treatment orders are required within 28 days. This results in a high number of orders not being reviewed because the people are discharged before their hearing.
- Some feedback, particularly from carers, suggests that because of the scheduling of hearings, the Tribunal is not seeing the person when they are unwell.
- Conversely, some people and advocates feel that the time delay results in the person being held for longer than they would otherwise have been.

- Insufficient emphasis is put on the provision of representation for people on orders, both before and at hearings.

See also discussion of the overlapping roles of the Mental Health Tribunal and the Guardianship and Administration Board in relation to medical treatment earlier in this paper (page 30).

- 43) *Should one model of appointment be applied to all tribunals associated with the Mental Health Act? If so, why? If not, why not?***
- 44) *Should the Act require a mix of skills on each division of the tribunals, including both a legal and medical member? If so, why? If not, why not?***
- 45) *Should there be an automatic right for people subject to orders to be given a statement of reasons for the Tribunal's decision? If so, why? If not, why not?***
- 46) *Should the timing of reviews of continuing care orders and community treatment orders be changed? If so, why and in what way(s)? If not, why not?***
- 47) *How can the provisions for representation of people subject to orders be strengthened?***
- 48) *Should the Act include a right of appeal? If so, where should that appeal be dealt with and on what criteria should it be allowed to proceed?***

## **Part 11 – Official visitors**

Generally the feedback we have is that these provisions work well but that they would be strengthened by the creation of a body to administer the provisions and to appoint official visitors. Currently appointments are made by the Governor on recommendation from the Minister.

The Solicitor-General has suggested a need to make it clear that the provisions apply equally to both hospital and community settings. It is not clear whether the provisions apply to services funded by the Government but provided by the non-government sector.

Section 4 of the *Health Act 1997* prevents official visitors from having access to incident reports, including those written in relation to entries in the Seclusion/Restraint Registers. This makes it extremely difficult to investigate some of the most serious complaints.

Young people are often placed in paediatric wards when hospitalised for mental health issues. Official visitors do not have access to these wards.

- 49) *Would these provisions be improved by the use of another style of administration? If so, in what ways? If not, why not?***
- 50) *Should official visitors have a role in the monitoring of services and treatment for all government-funded programs, including community settings and those services administered by the non-government sector? If so, why? If not, why not?***
- 51) *Should official visitors have access to surgical and other medical wards where a person may be detained due to a mental illness (for example paediatric and neurosurgical wards)? If so, why? If not, why not?***
- 52) *What records should official visitors have access to?***

## **Section 90 – Confidentiality**

One of the effects of section 90 is to prevent information about a person's ongoing treatment and illness being provided to family members where the person doesn't consent or lacks the capacity to consent to the disclosure of the information.

The other issue in relation to section 90 is that it doesn't provide for the disclosure of information about people using mental health services if that information is required or authorised by another law.

**See Questions 41 & 42**

- 53) *Should the Act allow for disclosure of information if required by law, as many other Acts do? If so, why, and what limitation should be placed on this? If not, why not?***

## **Young people in the mental health system**

Concerns have been raised because the Act does not require that young people be kept separate from adults in the secure mental health unit. Similar concerns have been raised in relation to other inpatient mental health facilities.

- 54) *Should the Mental Health Act require that the admission of young people to the secure mental health unit be conditional on the capacity to provide them with appropriate care and accommodation separately from adults? If so, why? If not, why not?***

## **Issues arising from related legislation**

The review includes legislation related to the Mental Health Act – the *Guardianship and Administration Act 1995*, the *Criminal Justice (Mental Impairment) Act 1999* and the *Sentencing Act 1997*.

### ***Guardianship and Administration Act 1995***

The main issue with this Act is in the role that it and the Guardianship and Administration Board have in authorising treatment for people with mental illness. The existence of two review bodies (the Guardianship and Administration Board and the Mental Health Tribunal) dealing with one group of people has been raised earlier in this paper.

**Questions arising from this issue are embedded in the earlier parts of the document. See:**

- **discussion of Part 4 of the Mental Health Act – Admission to approved hospitals and question 19 (page 28);**
- **discussion of Part 5 of the Mental Health Act – Medical treatment of people in approved hospitals and Questions 25–27 (pages 30,31); and**
- **discussion of parts 4 and 9 of the Mental Health Act – Mental Health Tribunal (starting on page 34).**

### ***Criminal Justice (Mental Impairment) Act 1999***

Under this Act, a court may make a continuing care order or community treatment order for a person who has been found not guilty of a crime by reason of insanity and in some other circumstances. Once made, the continuing care order or community treatment order is deemed to have been made under the Mental Health Act. Occasionally this has caused some problems when the order has later been discharged validly under the Mental Health Act despite an expectation by the court that the order would continue.

- 55) *Should the criteria applied in courts for making a continuing care order or community treatment order be the same as the criteria required by the Mental Health Act? If so, why? If not, why not?***

## **Sentencing Act 1997**

Similar issues arise with the Sentencing Act, under which courts may sentence a person to a continuing care order.

***See question 55 in relation to the criteria used by courts for making orders.***

## **The forensic provisions of the Mental Health Act**

The creation of these provisions has seen the adoption of two contrasting models and two contrasting systems. To some extent this is unavoidable because there is a difference between people using civil and forensic services – a difference created by the involvement of the criminal justice system. Some of the difference also occurs because the forensic provisions were created some time after the civil provisions and reflect a change in thinking over that time.

These provisions also saw the creation of a third external review body involved in mental health, namely the Forensic Tribunal. A different system was created for appointment of Forensic Tribunal members, leaving approval of members with a Minister, whereas the Mental Health Tribunal members are appointed by the Governor-in-Council.

A specific issue raised is the difficulty in applying the criteria for transfer of people detained involuntarily in a secure mental health unit.

- 56) To what extent should the forensic and non-forensic parts of the Mental Health Act be consistent? What, if any, changes would you recommend?***
- 57) Should one external body deal with reviews of people using civil services and people using forensic services alike? If so, why? If not, why not?***
- 58) Is there a need to refine or vary the criteria for transfer between an approved hospital and a secure mental health unit? If so, what changes are necessary? If not, why not?***
- 59) Should people who are admitted involuntarily and later transferred to the secure mental health unit continue to be dealt with largely as forensic patients? If so, why? If not, why not?***

## Useful resources

### Tasmanian law

The following acts may be viewed in full at [www.thelaw.tas.gov.au](http://www.thelaw.tas.gov.au)

- the *Mental Health Act 1996*
- the *Guardianship and Administration Act 1995*
- the *Criminal Justice (Mental Impairment) Act 1999*, and
- the *Sentencing Act 1997*

### The law in other Australian jurisdictions

The relevant Acts from other states and territories may be found at the following sites:

ACT	<i>Mental Health (Treatment and Care Act) 1994</i> <a href="http://www.legislation.act.gov.au/">http://www.legislation.act.gov.au/</a>
New South Wales	<i>Mental Health Act 1990</i> <a href="http://www.legislation.nsw.gov.au/">http://www.legislation.nsw.gov.au/</a>
Northern Territory	<i>Northern Territory Mental Health and Related Services Act 2005</i> <a href="http://www.nt.gov.au/dcm/legislation/current.html">http://www.nt.gov.au/dcm/legislation/current.html</a>
Queensland	<i>Mental Health Act 2000</i> <a href="http://www.legislation.qld.gov.au/">http://www.legislation.qld.gov.au/</a>
Victoria	<i>Mental Health Act 1986</i> <a href="http://www.mhrb.vic.gov.au/legislation/act.htm">http://www.mhrb.vic.gov.au/legislation/act.htm</a>
South Australia	<i>Mental Health Act 1993</i> <a href="http://www.legislation.sa.gov.au/">http://www.legislation.sa.gov.au/</a>
Western Australia	<i>Mental Health Act 1996</i> <a href="http://www.slp.wa.gov.au/statutes/swans.nsf">http://www.slp.wa.gov.au/statutes/swans.nsf</a>

### Publications

Department of Health and Human Services (2006), *Mental Health Services: Strategic Plan 2006–2011*, DHHS, Hobart.

Human Rights and Equal Opportunity Commission (1993), *Human Rights and Mental Illness: Report of the National Inquiry into the*

*Human Rights of People with Mental Illness, [the Burdekin Report], AGPS, Canberra.*

Department of Justice Canada (1982), *Canadian Charter of Rights and Freedoms*

Commonwealth Department of Human Services and Health (1995), *Model Mental Health Clauses Report to the Australian Health Ministers' National Advisory Council National Working Group on Mental Health, Canberra.*

Australian Health Ministers (2003), *National Mental Health Policy and Plan 2003-2008, Canberra*

*Attorney General's Department (1991) National Statement of Rights and Responsibilities, AGPS, Canberra*

United Nations (1992), *United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (MI principles), UN General Assembly Resolution 46/119, New York.*

## **Appendix 1: Strategic Plan 2006–2011 – Service Principles**

1. Single point accountability
2. Customer focused
3. Partnerships
4. Comprehensive service
5. Integrated and standardised
6. Mainstreamed
7. Least restrictive
8. Evidence based practice and outcome measures
9. Early intervention and assertive case management
10. Skilled and supported multidisciplinary workforce
11. Population based planning and service delivery

For a full explanation of these principles, see *Mental Health Services: Strategic Plan 2006–2011* pages 10–12:

[http://www.dhhs.tas.gov.au/agency/pro/mentalhealth/documents/Mental\\_Health\\_Full.pdf](http://www.dhhs.tas.gov.au/agency/pro/mentalhealth/documents/Mental_Health_Full.pdf)



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