

Review of the Mental Health Act 1996

Discussion Paper



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Table of Contents

Foreword	4
Background to the <i>Mental Health Act 1996</i> Review	4
Invitation to comment	5
Overview.....	6
Objects of the Act	10
Principle of minimum interference with Civil Rights.....	13
Treatment	14
Including the ability to treat without consent	14
Removal of consent by person responsible.....	17
A single tribunal	18
A treatment plan.....	19
Treatment Orders	20
A model for authorising involuntary treatment	24
Definition of treatment.....	29
Urgent treatment.....	31
Information requirements.....	32
Informed consent.....	33
Leave of absence	35
Definition of Mental Illness	36
Voluntary and involuntary treatment	38
Admission.....	38
Refusal of admission.....	39
Discharge from hospital.....	40
Power to take person into protective custody.....	41
Family carers and person responsible	45
Seclusion and bodily restraint.....	48
Review bodies	51
Official visitors	54
Chief Psychiatrist	56
Miscellaneous	60
Approved hospitals and assessment centres.....	60
Approval of medical practitioners and authorised officers	61
Young people	62
Interpreter services	62
Practice of religion	63
Areas not addressed in this Discussion Paper	64
The Tasmanian legislative framework for people with a mental illness.....	66
Summary of Recommendations	67
Development of this Discussion Paper.....	76
Useful resources	77
Tasmanian law	77
The law in other Australian jurisdictions	77
Publications	78
Appendix I: Strategic Plan 2006–2011 – Service Principles.....	79

Foreword

A New Mental Health Act for Tasmania

Analysis of the feedback from over 40 community consultations and over 70 written submissions indicated that Tasmanians seek fundamental changes to the current *Mental Health Act 1996*, above and beyond what could be achieved within the scope of the initial review process.

In the light of this clear message, the Minister for Health and Human Services has extended the scope of the review to incorporate the development of a new Mental Health Act for Tasmania. The new Act will be based on the current *Mental Health Act 1996* but will have a focus on treatment as opposed to the current focus of detention. The timeframe for the review has been extended and the new Act is due to be operational by July 2009.

To ensure that the extension of the timeframe does not cause disruption to the provision of mental health services under the current *Mental Health Act 1996*, the Minister has committed to extending the sunset clauses in relation to Community Treatment Orders until the new Act is in operation.

Background to the *Mental Health Act 1996* Review

The *Mental Health Act 1996* introduced significant changes in the delivery and review of mental health services in Tasmania. The legislation reflected modern approaches to the care of people with mental illness and was drafted following extensive community consultation.

The primary intention of the Act was to bring Tasmanian legislation into line with national and international standards in mental health. The philosophy underlying the Act was drawn from 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*. The Act was also informed by the *National Statement of Rights and Responsibilities* and the *Model Mental Health Legislation*.

In November 1999 the *Mental Health Act 1996* came into operation after a lengthy development and implementation process. It was intended that the operation of the *Mental Health Act 1996* be reviewed following a 12-month settling-in period to ensure that the Act facilitated effective practice, and to identify any need for further change. In October 2006 a comprehensive review of the *Mental Health Act 1996* began.

Since 1999 amendments have been made to the *Mental Health Act 1996*. In early 2005 an amendment was made to the Act to address the issue of non-enforceability of community treatment orders. The amendment has a three-year "sunset clause" ending in June 2008. Other major amendments were implemented in February 2006 to facilitate the operation of the Secure Mental Health Unit – the Wilfred Lopes Centre for Forensic Mental Health.

The current review of the *Mental Health Act 1996* is drawing on the experience of people with mental illness, carers, service providers and practitioners involved in the provision of mental health services since the implementation of the legislation in 1999. The review recognises that legislative reform of this nature is a balancing act of competing interests, such as risk to others and the rights of the individual. The review must carefully consider government responsibility to people with mental illness and government responsibility to the broader public.

Invitation to comment

You are encouraged to participate in the review of the *Mental Health Act 1996* by providing comment on the recommendations outlined in the discussion paper.

Please note that:

- You do not have to provide comment on all recommendations in the discussion paper; you may like to comment only on recommendations of particular interest to you.
- The discussion paper does not prevent you from raising other issues relevant to the review of the *Mental Health Act 1996*. We would like to hear about other sections of the *Mental Health Act 1996* which need reviewing.

You are invited to use the enclosed pro-forma for your written response. An electronic copy of this is available by following the links at www.dhhs.tas.gov.au. If you prefer not to use the pro-forma please identify the recommendations, on which you are commenting, 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 forums. If you cannot attend one of the forums, please contact us on 6230 7028 to determine how your information may best be provided.

Overview

Overview of key changes proposed to Tasmania's Mental Health Act

The most fundamental change proposed for the new Mental Health Act is a shift in focus from detention to treatment and to add the ability to treat without consent to the ability to detain in the Mental Health Act. Related to this proposal is a change from a focus on a hospital-based order to a treatment-based order.

Key features

Key features of the proposed model are:

- Any decision to provide treatment to a person without their consent, except in urgent circumstances, would only be able to be provided by an independent tribunal. (A person responsible would no longer be able to provide substitute consent for treatment).
- Treatment and detention would be provided for under a single order to be referred to as a "Treatment Order". (Initial orders would be retained and re-titled "assessment orders".) Detention would be included in the definition of treatment.
- A Treatment Order would cover both the situation of treatment within a hospital and community setting replacing the current Continuing Care Order and Community Treatment Order.

Definition of treatment

The definition of treatment would include any course of action, including detention, which is taken to remedy the mental illness or lessen the effects of the illness.

Specific provisions in relation to particular forms of treatment (eg electroconvulsive therapy (ECT) or psychosurgery) would be outlined in the regulations accompanying the Act.

Criteria for treatment

Involuntary treatment would only be able to be provided if all of the following factors were satisfied:

- the person appears to be mentally ill;
- the person's mental illness requires immediate treatment and treatment can be obtained by the person being subject to an involuntary treatment order;
- because of the person's mental illness, involuntary treatment is necessary for the person's health, safety or welfare (eg to prevent a deterioration in the person's physical or mental condition) or for the protection of members of the public;
- the person cannot receive adequate treatment for the mental illness in a less restrictive manner; and potentially
- the person has unreasonably refused or is unable to consent to the necessary treatment for the mental illness.

Additional safeguards

The majority of responses to the Issues Paper indicated support for involuntary treatment being included in the Mental Health Act on the basis that appropriate safeguards were included in the Act.

It is proposed that (in addition to the features mentioned above) the following safeguards be introduced in relation to involuntary detention and treatment:

- early and regular review of orders by an independent tribunal;
- the independent tribunal to require comprehensive treatment plans as the basis of any involuntary orders;
- inclusion of a medical member with recognised expertise in the field of psychiatry on all tribunal sittings;
- increased provision for legal representation offered to all people subject to orders appearing before the tribunal; and
- Treatment Orders to be reviewed on request of the person subject to the order.

Treatment in the community

Under the proposed model, a person on a Treatment Order would only be involuntarily detained if they met the criteria for involuntary treatment and that there was no less restrictive option available as part of their treatment plan. Otherwise they would be required to adhere to the conditions of their treatment plan while residing in the community. Should they fail to adhere to these conditions, they could receive involuntary treatment in an in-patient setting (ie at an approved hospital) or in regional centres. This may be provided at an approved treatment centre (such as a community health centre or the office of a general medical practitioner).

Process

(See Recommendation 13 on p. 24 for further detail and Diagram 1 below.)

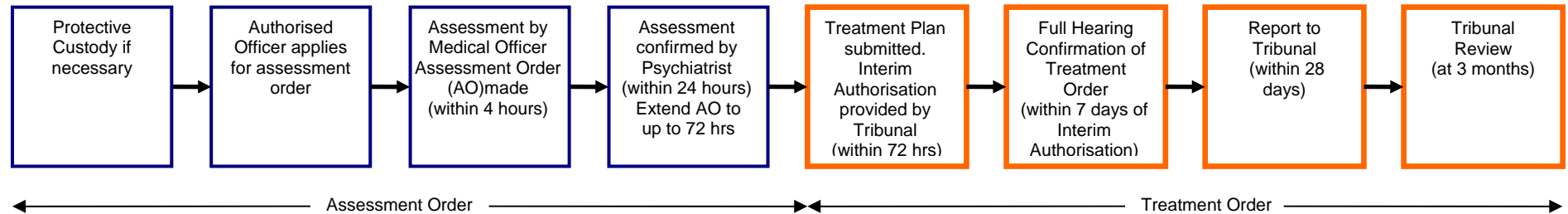
The pathway for such an order to be made would be as follows (see also Diagram 1):

- A person may be taken into protective custody by an authorised officer.
- An authorised officer could apply for an assessment order to be made.
- A Medical Officer would conduct an assessment (within four hours of admission) and if the criteria were met, make an Assessment Order for an initial period of 24 hours.
- An Authorised Medical Practitioner (ie a psychiatrist) would conduct an assessment and if the criteria were met, extend the Assessment Order to up to 72 hours.
- If a Treatment Order is required, a treatment plan must be developed and presented to an independent tribunal.
- Within 72 hours of the Assessment Order being made, a single member of the tribunal would either provide interim authorisation for the Treatment Order or reject the order.

- Within 7 days of interim authorisation the full tribunal would either confirm or dismiss the application for a Treatment Order. A full tribunal would comprise three members including a legal and medical member.
- A report would be made to the tribunal at the 28-day stage in relation to the need to continue the order. The Tribunal will determine whether this report should result in a hearing.
- At three months, the tribunal will conduct a review of the order.
- After six months the order expires. If a further order is required, application must be made to the tribunal.
- After consecutive six-month orders, a 12-month order may be sought from the tribunal. Such an order would involve three-monthly review or reporting at a minimum.
- The person subject to the order can request a review at anytime during the life of the order.

Diagram I

Proposed Pathway for Treatment Orders

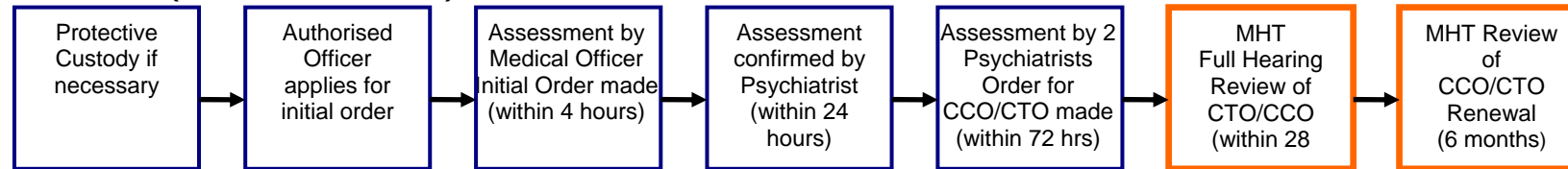


Notes:

- Person subject to Treatment Order may request review at any time
- Treatment Order – may be made for up to 6 months duration. Renewal would require a Tribunal Hearing.
- Clinical Decision
- Review stage

Current Review Pathway for Involuntary Treatment and Detention

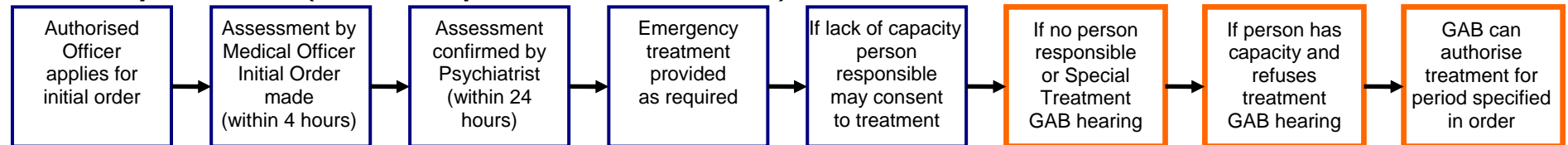
Detention (Mental Health Act)



Notes:

- CCO – Continuing Care Order
- CTO – Community Treatment Order
- CCO/CTO – may be made for up to 6 months duration

Involuntary Treatment (Guardianship and Administration Act)



Notes:

GAB – Guardianship & Administration Board

Objects of the Act

Recommendation 1

- a) *That the objects of the Mental Health Act 1996 be retained.*
- b) *That the objects of the Mental Health Act be broadened to reflect the United Nations' Principles on the Care and Protection of People with a Mental Illness and for the Improvement of Mental Health Care, the National Mental Health Policy and Plan, the National Standards for Mental Health Services (encompassing the National Mental Health Statement of Rights and Responsibilities), the Model Mental Health Legislation and the Tasmanian Mental Health Services Consumer and Carer Participation Framework.*
- c) *That the objects of the Mental Health Act include a focus on human rights.*

Recommendation 2

- a) *That the Mental Health Act include objects of service for Tasmanian Mental Health Services.*
- b) *That the objects of service and the strategic principles of the Tasmania Mental Health Strategic Plan 2006–2011 be consistent.*

Current position

National and international standards are embodied in the objects of the current *Mental Health Act 1996*.

The objects 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.

Consultation response

Few responses provided specific comment in relation to the objects of the current *Mental Health Act 1996*. Comments received included the following:

- The right to respect for individual human worth, dignity and privacy should be included in the objects of the Tasmanian *Mental Health Act 1996*. This right is the first consumer right outlined in the *National Statement of Rights and Responsibilities*. The objects of the Act currently do not adequately substitute for the intent of this right.
- The principles in the objects of the Tasmanian Mental Health Act relating to a person's rights are limited.
- The issues for consideration should be whether or not the objects of the Act are appropriately representative of human rights presently and whether they are given proper regard in the provisions in the Act, and in the policies and practices of mental health services, including the present review of the *Mental Health Act 1996*.
- Until such time as encouragement and support are available to assist those with a mental illness to function at their highest possible level within their community, it seems that no amount of liberally worded legislation will really have an impact.

Rationale for Recommendations 1 a), b), c), 2 a) & b)

The objects of the *Mental Health Act 1996* embody national and international standards. The human rights approach of the present Act is consistent with 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 current objects of the *Mental Health Act 1996* do however require expansion to reflect the more contemporary direction being undertaken in the provision of mental health services and to ensure appropriate representation of human rights. This is significant because the objects will be the central guide to the Act and the legislation will be interpreted to give greatest effect to the objects.

Legislation in other jurisdictions includes a provision similar to objects of service. The Australian Capital Territory contains objects of the Act and objects of the Territory. The objectives of the Territory are contained in Section 8 of the *Mental Health (Treatment and Care) Act 1994* and are service objectives in relation to the provision of ACT mental health services. Similarly in New South Wales legislation, the *Mental Health Act 1990* provides for the objectives of the Department. These are objectives which outline service principles for the relevant Department. The introduction of service objectives to the Mental Health Act would enable the service principles of the Tasmanian *Mental Health Services Strategic Plan 2006–2011* to be encompassed within the Mental Health Act as service objectives. This will provide legislative weight to strategic principles which were developed throughout a three-year consultation period with over 700 Tasmanians, eager to see improvement in the delivery of mental health services.

Principle of minimum interference with Civil Rights

Recommendation 3

That the principle of minimum interference with civil rights be retained in the Mental Health Act.

Current position

Section 7 of the *Mental Health Act 1996* provides a clear direction that when a person is involuntarily detained, the following principles must be observed:

- Restriction on the liberty of the person and interference with the person's rights, dignity and self-respect must be kept to a 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.

Consultation response

The need to ensure minimum interference with the civil rights of people with mental illness was a predominant theme.

Rationale for Recommendation 3

The recommendation has been made that the Mental Health Act should include provision for involuntary treatment. This needs to be balanced with appropriate legislative protections for people with a mental illness based on a principle of minimum interference with civil rights. The recommendation is also consistent with Principle 9 of the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* which states "that every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others".

Treatment

Including the ability to treat without consent

Recommendation 4

That the Mental Health Act include the ability to treat without consent in appropriate circumstances.

Current position

Currently Tasmania's *Mental Health Act 1996* is constructed around involuntary detention. Involuntary orders provide for detention rather than treatment and, apart from emergency situations, treatment without consent can only be provided with the substitute consent of the person responsible or the Guardianship and Administration Board.

Under the current legislation, treatment without consent is provided for in five circumstances:

- i) In emergency situations, in which Section 40 of the *Guardianship and Administration Act 1995* allows urgent treatment to be provided when a person is incapable of giving consent. There is no requirement that the board be consulted in relation to this treatment.
- ii) Where a person is considered not capable of providing informed consent, a person responsible may provide substitute consent for treatment. In practice, this is by far the most common way in which substitute consent is provided (s. 39 *Guardianship and Administration Act 1995*).
- iii) Where a person is considered not capable of providing informed consent and there is no person responsible willing to provide consent, the Guardianship and Administration Board can authorise treatment on the basis of a "best interests" test (s.41 *Guardianship and Administration Act 1995*).
- iv) Where a person has capacity and refuses consent, Section 32 of the *Mental Health Act 1996* provides that the Guardianship Board can authorise treatment in the interests of the person or for the protection of others. This section, however, is rarely used because it has been interpreted to only refer to treatment within an approved hospital. In most situations the person lacks capacity to consent and it is possible to apply the provisions of the *Guardianship and Administration Act 1995* Part 6, which allow for substitute consent in these circumstances.
- v) In urgent circumstances Sections 72H, 72I and 72J of the *Mental Health Act 1996* state that the Chief Forensic Psychiatrist may approve treatment for people in the secure mental health unit for an initial period of up to 96 hours.

Consultation response

Consultations indicated broad support for the inclusion of involuntary treatment into the *Mental Health Act 1996*. Common themes of consultation responses included:

- Concerns that it seemed pointless and even unethical to detain a person if the service is not able to treat them. It has been argued that if an individual is to be detained against their will, there is a moral and ethical obligation to treat the person so that they may be discharged as soon as possible and no longer held against their will.
- Concerns by practitioners that involuntary detention and involuntary treatment are currently dealt with by separate review bodies (the Mental Health Tribunal and the Guardianship and Administration Board) and two Acts.
- Including the ability to treat without consent in the Act would mean earlier intervention and provide a better chance of recovery, including a better quality of life for some people with a severe mental illness.
- There should be capacity to treat those who are at serious risk of causing harm to themselves or others and who will not voluntarily undertake treatment.
- Should the concept of involuntary detention be included in the Act, strong safeguards would be required, especially in relation to people who have the capacity to make an informed choice in relation to treatment.

There were some responses strongly opposed to including involuntary treatment in the *Mental Health Act 1996*, especially in relation to legally competent persons. Key arguments from these responses included:

- It is an abuse of human rights to treat someone against their wishes and is a breach of the UN *Principles for the Protection of Persons with a Mental Illness and the Improvement of Mental Health Care*.
- It is in contravention of a fundamental legal principle that a person is able to refuse medical treatment however beneficial it may be to them (see *Re MB (Medical Treatment)* [1997] 2 FLR 426).
- It is “swimming against the international tide” to treat legally competent and capable persons (reference was made to European & US jurisdictions).
- Tasmania is not ready for its law to allow involuntary treatment of its mentally ill citizens because there are insufficient safeguards in place.
- Forcible treatment works in opposition to the recovery model.
- Provision for involuntary treatment will revive and expand stigma levels and discrimination against consumers.
- Treatment without consent should continue to be dealt with by the Guardianship and Administration Board, because it has the expertise in deciding on treatment issues, provides an additional safeguard for people with a mental illness and has an effective and efficient structure in place.

Rationale for Recommendation 4

Involuntary treatment is provided for under current Tasmanian law

As indicated above, although the Tasmanian Mental Health Act is primarily concerned with involuntary detention, the Act allows the Guardianship Board to make decisions enabling people with a mental illness to be treated against their will, including in relation to people with the capacity to make informed decisions.

A right to treatment

As many respondents to the Issues Paper indicated, 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.

Greater accountability

Under current provisions, an emergency guardianship order authorising involuntary treatment can be obtained on the basis of a telephone call and not reviewed for 28 days. Guardianship Orders can be made for indefinite periods without review. The recommended changes provide that any proposal to treat will be considered by an independent body within three days and further by a full tribunal within ten days.

Promotes recovery

There are a number of people in the community who lack insight into their mental illness and who will have a much better quality of life as a result of involuntary treatment. Many people with a mental illness have supported this proposal on the basis that when they are unwell they will not consent to treatment, but on other occasions are aware that treatment is fundamental to their wellbeing.

For the protection of (self and) others

Sometimes the responsibility of a state toward its citizens requires balancing the rights of individuals with the rights of the people around them. It is considered that when a person has a treatable mental illness and as a result of that mental illness the person is a danger to themselves or others, the State has a duty to intervene and provide treatment to that person, even though they may have made a competent and informed choice not to consent to treatment.

Consistency with Australian law and the UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care

Provision for the involuntary treatment of people with and without the capacity to make an informed consent is consistent with the UN's *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* under Principle 11 (6), which states that a proposed plan of treatment can be given to a person without the person's informed consent if the person is an involuntary patient, an independent authority is satisfied the person lacks the capacity to give or withhold consent, or there is an issue of the person's safety or the safety of others, and the independent authority is satisfied the proposed plan of treatment is in the best interests of the person.

The recommendation is in accordance with mental health legislation in all Australian states and territories. Involuntary detention is provided for in the Model Mental Health Legislation drafted in 1994 with a view to implementing consistent mental health legislation throughout Australia. These legislative provisions have been specifically designed to override the common law situation that a person can refuse medical treatment when they fulfil the criteria for involuntary treatment.

Removal of consent by person responsible

Recommendation 5

That the ability of the person responsible to provide substitute consent to psychiatric treatment be removed.

Recommendation 6

That the ability to consent to treatment will, except in urgent circumstances, only be exercised by an independent tribunal.

Current position

The *Guardianship and Administration Act 1995* provides that when a person is considered not capable of providing informed consent, a person responsible may provide substitute consent for treatment. In practice, this is by far the most common way in which substitute consent is provided.

Consultation response

There were a number of responses raising concerns in relation to the role of the person responsible in being able to authorise treatment. These responses raised the following issues:

- There are instances when the person responsible identified by clinical staff does not have a close or ongoing relationship with the person with a mental illness.
- The request to authorise treatment places undue pressure on the person responsible and often harms the relationship between them and the person with a mental illness.
- Spouses, carers, friends and relatives should not be placed in the position of having to make judgements about the need for psychiatric treatment when they may have little knowledge about mental illness or the rights of people with a mental illness.

Some people with a mental illness said that it would be good to be able to nominate whom their person responsible should be.

Rationale for Recommendations 5 & 6

Some people providing ongoing care to a person with a mental illness will have an intimate knowledge of the person, their illness and factors impacting on their illness and will be able to make informed judgments whether the person should be provided with treatment or not.

It is of considerable concern, however, that a person responsible, who may have little or no current connection with the person who may receive treatment, and who may have little understanding of their mental illness, may make a decision on their behalf that they receive treatment. This person is unlikely to have the relevant expertise to make this judgment and there is no guarantee that they are in a position to consider, or will consider, all the relevant criteria about whether the treatment is truly in the best interests of the person.

Even when the person responsible can fulfil the obligations of this role in good faith, the experience of many carers and family members is that this decision damages the relationship with the person

who has been treated without their consent, and in turn impinges on their ability to provide care and support for them in the future.

It is considered to be a far more effective safeguard for the interests of the person with a mental illness that any decisions (with the exception of situations requiring urgent medical treatment) about treatment, for which they are unable to consent, are made by an independent tribunal with appropriate expertise to consider both the relevant legal and medical issues. This tribunal could invite persons involved in the ongoing care of the person for whom treatment is proposed to inform the tribunal about other issues relating to the treatment and welfare of the person.

A single tribunal

Recommendation 7

That all issues dealing with the Mental Health Act be dealt with, where possible, by a single tribunal, at one hearing.

Current position

Matters of detention are dealt with by the Mental Health Tribunal and matters about the treatment of people with a mental illness are dealt with under the *Guardianship and Administration Act 1995*.

Consultation response

There was broad support for the proposal that matters in relation to both treatment and detention of persons with a mental illness be dealt with by a single tribunal.

There was opinion expressed that treatment without consent should continue to be dealt with by the Guardianship and Administration Board, because it has the expertise in deciding on treatment issues, provides an additional safeguard for people with a mental illness and has an effective and efficient structure in place.

Rationale for Recommendation 7

Tasmania is the only Australian jurisdiction where detention and treatment are reviewed by two different bodies.

The current system of two separate bodies deciding about detention and treatment issues is confusing and sometimes requires more than one hearing for the same person, which results in unnecessary stress to that person at a time when they are acutely unwell and is a poor use of clinicians' time. A single tribunal will resolve these issues.

A treatment plan

Recommendation 8

That application for a Treatment Order and subsequent reports and reviews must include a detailed treatment plan. So far as is possible, the person and, unless the person objects, the wishes of those providing ongoing care must be included in the development and the ongoing implementation of the treatment plan.

Current position

There is no requirement that a treatment plan be prepared and provided to the Mental Health Tribunal or Guardianship Board for consideration.

The *Mental Health Act 1996* (s. 45) requires that a statement of the nature of the proposed treatment be given as soon as practicable after a diagnosis is made to a patient and a person responsible. This statement is normally made in the most general of terms, for example “will remain in hospital and receive medication”. The statement does not require a treatment plan to be provided, nor does it require any updating of the information during the course of the involuntary admission.

Consultation response

This issue was not specifically addressed in the Issues Paper, but there were responses that referred to the importance of a treatment plan in providing transparency in relation to treatment decisions and ensuring continuity of care.

The President of the Mental Health Tribunal recommended that the Act require that a treatment plan be prepared for all involuntary patients and that this plan be reviewed by the supervising medical practitioner (at least every three months) and if necessary updated.

The basis of this recommendation was that this was a service guarantee ensuring that the State fulfilled its obligation to provide treatment and care to persons who have their autonomy curtailed by mental health orders. It was noted that in most other Australian jurisdictions there is a requirement that the relevant tribunal reviews treatment plans for persons subject to orders. The Victorian legislation was provided as an example.

Rationale for Recommendation 8

It is considered fundamental to ensuring the ongoing provision of appropriate care for persons subject to involuntary orders in Tasmania that comprehensive treatment plans are prepared. Good practice dictates that where possible the person subject to the plan is involved in its ongoing development and that, where appropriate, the wishes of relevant family and carers are taken into account. This is also in accordance with the *Tasmanian Mental Health Services Consumer and Carer Participation Framework*. When relevant parties are able to assist in the development of a plan, it is more likely that it will be appropriate to the circumstances of the person concerned and that it will be followed.

The requirement that treatment plans for involuntary patients be provided to the independent tribunal would mean that greater transparency is provided to treatment planning and would be of

considerable assistance to the tribunal in determinations as to whether involuntary orders are necessary.

Clearly the opportunities will be limited for the person with the mental illness and appropriate others to be involved in the initial development of the plan that is presented to the tribunal for interim authorisation of a Treatment Order. It is envisaged that the development of the plan will be ongoing and its will be monitored at each point that this matter comes before the tribunal (ie within ten days, 28 days, at three months and beyond).

Treatment Orders

Recommendation 9

That an Initial Order be renamed an Assessment Order.

Recommendation 10

That a single order, to be referred to as a Treatment Order, deal with all treatment issues including detention. This order will replace the current Continuing Care Order and Community Treatment Order.

Recommendation 11

That the Mental Health Act provides that people subject to a Treatment Order who refuse to comply with their treatment plan may be treated involuntarily in an “approved treatment centre” (which would include an approved hospital).

Recommendation 12

That the primary purpose of a Treatment Order will be to facilitate assertive case management providing for treatment while the person continues to reside in the community.

Further explanation

Once a person is assessed as meeting the criteria for a Treatment Order, the decision must be made whether the person requires detention. A decision to detain will be based on a judgment that there is no less restrictive option available as part of the person’s treatment plan. The need for detention or otherwise will be indicated on the order.

A person who is detained may be transferred to the care of a Community Mental Health Team on the authorisation of an Authorised Medical Practitioner (ie psychiatrist). The person’s treatment plan will continue to operate in the community setting. Should the need arise that the person be readmitted, this will require authorisation by a Medical Officer and confirmation by an Authorised Medical Practitioner (see Diagram 2).

When a person who is residing in the community refuses to comply with their treatment plan, they may be treated involuntarily (if the criteria for involuntary treatment are met). It is proposed that this will generally occur at approved hospitals (ie one of the three regional hospitals in Burnie,

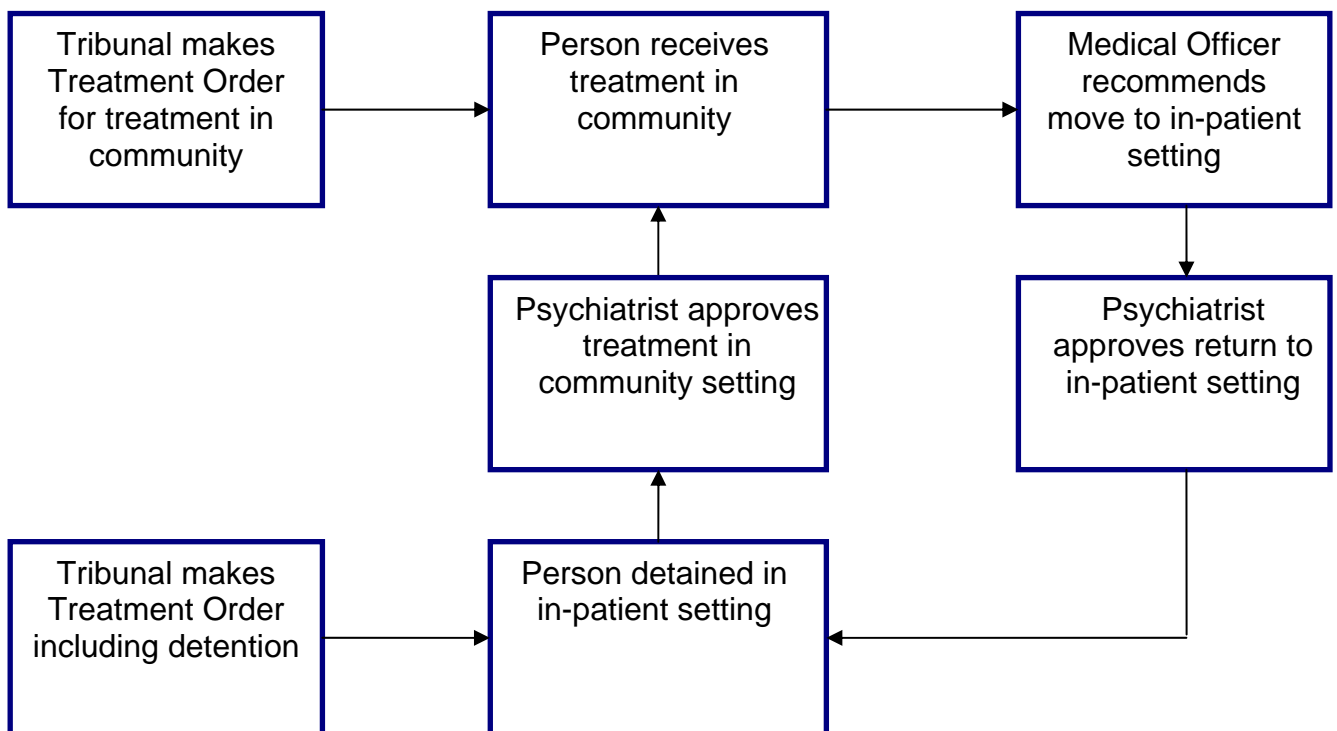
Launceston or Hobart), but it may be that other centres, especially in more isolated areas, may be approved as “approved treatment centres” to avoid the need that the person be transported long distances from their place of residence. In this case it is envisaged that the person’s treatment plan would specify the clinician(s) who would provide treatment in this eventuality.

Police assistance could be requested to enable this treatment if considered necessary.

Diagram 2

Treatment Order

Steps in moving between in-patient and community setting



Current position

Currently under the *Mental Health Act 1996*, an Initial Order and Continuing Care Order provide for detention and a Community Treatment Order provides for treatment in a community setting. If clinicians are of the opinion that an involuntary order is required on discharge from hospital, a Community Treatment Order must be initiated. Initiating a Community Treatment Order requires the authority of two psychiatrists.

On breach of a Community Treatment Order a person may be returned to hospital under an Authorised Temporary Admission which provides for involuntary detention, but they may not be

treated involuntarily under this order. An authorised temporary admission requires the approval of a medical practitioner and a psychiatrist.

Consultation response

There was widespread agreement that a single order that dealt with both detention and treatment and that covered both hospital and community settings would be beneficial.

It was commonly suggested that it was logical and efficient to deal with both detention and treatment at once and that having a single order that was easily extended to a community situation would make it more likely that there would be coordination between hospital and community mental health services.

Concerns were expressed in relation to any streamlining on the basis that efficiencies are only likely to benefit services and not patients.

There was considerable agreement in relation to the ineffectiveness of Community Treatment Orders under the current Act on the basis that they are only enforceable by hospitalisation and that they do not necessarily result in treatment.

Some submissions cast doubt on the effectiveness and desirability of community treatment orders generally, citing a recent report in relation to international Community Treatment Order legislation and practice.¹

Some responses were very clear that there should not be involuntary treatment in other than a hospital setting and one cited the previously mentioned report as evidence that there was universal support for the principle that involuntary treatment not be permitted in the community.

Rationale for recommendations 9, 10, 11 & 12

Recommendation 9:

The term assessment order more accurately reflects the purpose of an initial order and this terminology should be helpful to people's understanding of the operation of this order.

Recommendations 10, 11 & 12

A single order for detention and treatment

The focus of the new Act will be on treatment. Detention will be considered to be an option available to clinicians as part of a treatment plan (only to be considered when there is no less restrictive option available). A single order reflects the idea that detention is part of the continuum of treatment and that detention will only be available in order to facilitate effective treatment and not an end in itself.

A single order considered by a single tribunal means that one authority can make decisions in relation to the totality of the interventions affecting a person potentially subject to an order. A single order will mean fewer tribunal appearances for people subject to orders and for clinicians.

¹ J Dawson, *Community treatment orders: international comparisons*, University of Otago, 2005.

A single order for hospital and community

A single order, based on a treatment plan, for both in-patient and community settings will reinforce the idea and practice of the concept of continuity of care. It is envisaged that the treatment plan reviewed by an independent tribunal will anticipate the likelihood of this transfer of care from an in-patient to a community setting and prescribe the support to be provided to the person in the community.

This will resolve the anomalous situation in which a person who is already on a more restrictive Continuing Care Order must be assessed by two psychiatrists so that they may be placed on a less restrictive Community Treatment Order, which may also require a second tribunal hearing. The process proposed is that a single psychiatrist will be able to approve the transfer of a person subject to a Treatment Order from an in-patient to a community setting.

Involuntary treatment in a community setting

Currently people on Community Treatment Orders cannot be compelled to undertake treatment. Breach of an order means that a person can be involuntarily detained, but not treated without their consent. It is clear that orders without enforcement mechanisms are of very limited use and that threatening people with hospitalisation so that they will consent to treatment cannot be supported as ethical practice. When a person fulfils the criteria to be on an involuntary order (including, for example, that they have a mental illness and that they are a danger to themselves or others) and they refuse the treatment indicated in the treatment plan, the appropriate response is that treatment should be able to be provided involuntarily.

In relation to concerns that a community setting, such as a community health centre, does not have the medical and security resources necessary to ensure safe provision of forcible treatment, it is suggested that, where use of force is considered necessary, police assistance could be requested and that people could be taken to an in-patient unit in an approved hospital.

The experience of clinicians is that when people are aware that treatment may be compelled, compulsion is rarely necessary.

A least restrictive option

Recent analysis of the effectiveness of community treatment orders is viewed with considerable interest. The international debate about how to effectively provide for involuntary treatment in a non-hospital setting has a long history and is ongoing. Despite this debate, a commitment to a system for involuntary treatment in the community is retained in this proposed legislation because of a commitment to the principle of pursuing the least restrictive intervention for people subject to the Act.

This approach is consistent with Principles 3 and 9 of the UN's *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*:

- “Every person with a mental illness shall have the right to live and work, to the extent possible, in the community” (Principle 3).

- “Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient’s health needs and the need to protect the physical safety of others” (Principle 9.1).

A model for authorising involuntary treatment

Recommendation 13

That the model described below (see also Diagram 1) be adopted as the model for authorising treatment, including detention, under the Mental Health Act.

Further explanation

The pathway for such an order to be made would be as follows (see also Diagram 1):

- A person may be taken into protective custody by an authorised officer (ie experienced mental health clinician, general medical practitioner, police officer of a certain rank, delegated ambulance officer).
- An authorised officer could apply for an assessment order to be made.
- A Medical Officer (ie a general medical practitioner/psychiatric registrar/psychiatrist) would conduct an assessment (within four hours of admission to the assessment centre) and if the criteria were met, make an Assessment Order for an initial period of 24 hours.
- An Authorised Medical Practitioner (ie a psychiatrist) would conduct an assessment and, if the criteria are met, extend the Assessment Order up to 72 hours. Emergency Treatment for involuntary patients could be provided at this time (as is currently the case).
- If a Treatment Order is required a treatment plan must be developed and presented to an independent tribunal.
- Within 72 hours of the Assessment Order being made, a single member of the tribunal would review the treatment plan and, if they were satisfied that the relevant criteria for an order were met, provide interim authorisation for the Treatment Order.
- Within seven days of interim authorisation the full tribunal would view the treatment plan, consider the application for a Treatment Order and either confirm or dismiss the application. A full tribunal would comprise three members including a legal and medical member.
- A report would be made to the tribunal at the 28-day stage in relation to the need to continue the order (if the order has not already been revoked). The tribunal will determine whether this report should result in a hearing at this stage.
- If the order is still current after three months, the tribunal will conduct a review of the order.
- After six months the order expires. If a further order is required, application must be made to the tribunal. If a further order is granted it will be reviewed at three months.
- After consecutive six-month orders, a 12-month order may be sought from the tribunal. Such an order would involve a three-monthly review or reporting at a minimum. Renewal of a 12-month order would require a tribunal hearing.
- The person subject to the order can request a review at anytime during the life of the order, provided that they are not requesting a reconsideration of information already presented at a

hearing (a reconsideration of information presented at a hearing would constitute an appeal – see Recommendation 44).

Current position

Currently involuntary treatment is most often authorised by persons responsible. In the absence of consent by the person responsible, treatment can only be authorised by the Guardianship and Administration Board except in emergency situations (see Diagram 2, p. 34 for further detail). There is no requirement for review of treatment orders authorised by the Guardianship and Administration Board.

Under the *Mental Health Act 1996*, 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 another person who has an interest in their welfare.

Consultation response

Few responses specifically addressed the issue of a model for treatment to be included in the mental health orders, but specific features of this model were addressed.

One proposal was that the model used should be based on the guardianship model whereby the guardian would have an ongoing relationship with the person, would be required to take into account the wishes of the person (which could be stated in advance) and to make decisions based on their best interests.

Responses were clear that the review periods for involuntary detention should be brought forward from the current 28-day period and that the tribunal should include medical expertise.

There was clear support for the mandatory inclusion of a medical member on any tribunal hearing matters in relation to treatment or detention.

Rationale for Recommendation 13

This model provides a range of new safeguards in acknowledgment of the fact that a decision to treat someone without their consent or against their will is a fundamental breach of their right to bodily integrity. This right will only be overridden on the basis of a state's duty to protect its citizens (ie both the person in question and other people).

A guardianship model is considered to be a more restrictive model than a system of involuntary orders subject to regular review. A guardianship model is considered to be most appropriate for people with an ongoing disability that impairs their capacity, rather than a short-term or intermittent condition from which people recover a decision making capacity. Mental Health orders continue only as long as necessary and may be easily revoked at the point when they are no longer considered necessary.

The most significant feature of this model, in terms of protection for the rights of persons with a mental illness, is the early involvement of an independent tribunal comprising legal and medical expertise, which on the basis of a proposed treatment plan, will decide on treatment and detention issues. This model proposes independent consideration of treatment and detention issues within three days of a person being initially assessed and further consideration by a three-member tribunal within ten days. The model contemplates a report to the tribunal within 28 days, at which point the tribunal will determine whether a hearing is necessary.

As mentioned above, Guardianship and Administration Board decisions about treatment currently do not need to be reviewed. Orders for detention and community treatment under the *Mental Health Act 1996* currently do not need to be reviewed for 28 days.

At 28 days approximately two-thirds of mental health orders made in Tasmania have been discharged. The average length of a Continuing Care Order is 13 days. Many people who are repeatedly subject to involuntary orders in Tasmania never have their order reviewed by the Mental Health Tribunal. These earlier review periods would ensure that almost 100 per cent of orders are reviewed and at an early stage.

It is acknowledged that the emphasis on the early intervention by the Independent Tribunal (ie within ten days) may limit initial ability of the person to participate fully in the process. However, it is considered in the best interests of the person that independent consideration of the order should occur as soon as possible. This is consistent with Principle 17 of the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* that states that the initial review of a decision to admit or retain a person as an involuntary patient shall take place as soon as possible after the decision.

In addition to the early tribunal consideration of the matter, the person subject to the order may request a review at any stage. The report at 28 days may result in a review if required and review is scheduled at the three-month stage.

The inclusion of a medical member for all matters going to a full tribunal would ensure that there is the appropriate expertise to examine proposed treatment options.

The mandatory development and provision of treatment plans would ensure greater transparency of treatment decision-making.

Recommendation 14

That all of the following criteria be met prior to making a Treatment Order:

- *the person appears to be mentally ill;*
- *the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order;*
- *because of the person's mental illness, involuntary treatment of the person is necessary for his or her health, safety or welfare (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public (welfare to include reputation and financial wellbeing); and*
- *the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.*
- *That there be further consideration as to whether the following be included as part of the criteria for a Treatment Order:*
- *the person has unreasonably refused or is unable to consent to the necessary treatment for the mental illness.*

Further explanation

These criteria are based on those in the Victorian *Mental Health Act 1986* and are similar to criteria used in other states to determine the basis for involuntary treatment.

One amendment made to the Victorian criteria is that involuntary treatment may be authorised when it is considered necessary to prevent damage to a person's reputation or financial circumstances (welfare). This is similar to the New South Wales and Western Australian provisions, which include financial harm and loss of reputation in the criteria allowing involuntary treatment.

A further change that is being considered is whether to recommend the inclusion of the criterion, "the person has unreasonably refused or is unable to consent to the necessary treatment for the mental illness". The committee is seeking to reconcile a range of concerns in relation to this provision.

There is concern that, if a test of capacity is required, this would be burdensome and unnecessary for clinicians, when in reality the end result would be the same (provided that the other criteria are satisfied), that treatment can be provided without consent whether; i) the person lacks capacity and is unable to consent or ii) has capacity and refuses. According to this view the key issue is the health, safety and welfare of the person and the protection of members of the public. The issue of capacity to consent is secondary to the clearly established need for treatment.

An alternative view is that it is significant that these criteria remain. Otherwise the provision allows (provided the other criteria are satisfied) for treatment of people with capacity who have reasonably refused treatment, for example on the grounds of the serious side-effects of the medication that the person has experienced or the ineffectiveness of the medication for their condition. Part of this view is that psychiatric medicine is an inexact science and diagnoses cannot always be guaranteed to be accurate.

Current position

When the person lacks to the capacity to provide informed consent, the *Guardianship and Administration Act 1995* provides that a person responsible may provide substitute consent to medical treatment. In the absence of a person responsible, the Guardianship Board may authorise treatment if the board is satisfied that the treatment is in the best interests of the person. When a person with a mental illness who has the capacity to make an informed consent refuses treatment, the Guardianship Board may make an order authorising treatment based on the interests of the person or the protection of other people.

Consultation response

The criteria for involuntary treatment were not specifically identified in the Issues Paper and few responses addressed this issue.

As mentioned above some responses were clearly opposed to any criteria that allowed the involuntary treatment of legally capable persons.

There was some support for legislating that practitioners could take a long-term view of potential harm to a person's health, rather than a short-term view.

There was some support for criteria including harm to reputation and to financial circumstances. Case studies were provided to illustrate the harm that a person can cause to their's and their family's personal and financial situations when their mental illness is allowed to continue untreated.

Further criteria proposed included: diminished capacity to care for oneself (as in New Zealand's *Mental Health (Compulsory Assessment and Treatment) Act 1992*); long-term impairment of health; and lack of ability to resist sexual or financial exploitation.

Rationale for Recommendation 14

This criteria described above are proposed on the basis that:

- They provide for intervention when required to ensure the safety of both the person with a mental illness and the people around them.
- They provide for intervention based on preventing long-term deterioration of the person's mental and physical condition (due to the mental illness).
- The prerequisite that a person requires "immediate" treatment before an order is initiated is in accordance with the principle of least restrictive practice. The purpose of including the requirement for an immediate need for treatment is to ensure that involuntary orders are only used when other options (eg supporting the person to voluntarily seek treatment) have been exhausted.
- It is proposed that "immediate" be defined not to exclude ongoing treatment so that a person who, for example, requires fortnightly medication, would not have to be taken off the order following each instance of medication and put back on before the next one.

- By adding the word “welfare” with its accompanying definition, intervention is provided for regarding damage to reputation and financial wellbeing. These provisions were considered to be particularly relevant to the situation of persons experiencing mania. There are numerous case examples of persons in this state seriously damaging their reputation through grandiose statements and damaging their financial situation through excessive spending.

Definition of treatment

Recommendation 15

That the definition of Treatment:

- includes detention; and
- refers to professional intervention to remedy the mental illness; or lessen its ill effects or the pain and suffering which it causes.

Current position

Treatment is not currently dealt with in the *Mental Health Act 1996*. The *Guardianship and Administration Act 1995* refers to medical or dental treatment, and excludes non-intrusive examinations, first-aid or non-prescription medications from this definition.

“Special treatment”, including treatment resulting in infertility or termination of pregnancy, involving removal of non-regenerative tissue, involving drugs of addiction or aversive stimuli, is dealt with separately under the *Guardianship and Administration Act 1995* and its regulations (see Recommendation 13).

Consultation response

The definition of treatment was not canvassed in the Issues Paper and was therefore rarely addressed in responses. Some responses indicated that there should be a definition of treatment in the Act and one response suggested treatment must be something that is necessary and beneficial to the person.

Rationale for Recommendation 15

This definition is based on the definition of treatment in the Victorian *Mental Health Act 1986* and is similar to definitions used in other Australian jurisdictions.² This definition provides a broad interpretation of treatment to include, not just medical treatment, but all forms of professional intervention, including counselling and social interventions.

It is proposed that the definition (unlike in other jurisdictions) should specifically include detention, so that it is clear to people using the Act, that this is what is intended. This allows for the situation in

² See also: *Northern Territory Mental Health and Related Services Act 2005* and *Queensland Mental Health Act 2000*.

which the most appropriate form of intervention for a person may be that they remain in an in-patient facility until their condition abates.

Recommendation 16

That regulations be created determining processes for particular treatment aspects that are considered to present higher risks (eg Electro-Convulsive Therapy and Psychosurgery).

Current position

The safeguards in relation to treatment options that have more fundamental consequences and/or are considered to present higher risks include:

- treatment resulting in infertility or termination of pregnancy;
- removal of non-regenerative tissue;
- drugs of addiction or aversive stimuli;
- electro-convulsive therapy; or
- psychosurgery.

These are dealt with separately under the *Guardianship and Administration Act 1995* and its regulations.

Consultation response

This was not an issue addressed in the Issues Paper and few comments were made in relation to this topic. Some responses stated that treatments for involuntary patients, such as drug therapy and electro-convulsive therapy, should require communication with the person's treating general practitioner or a medical examination prior to commencement of the treatment.

Rationale for Recommendation 16

Some treatment options require additional safeguards because of the potential for serious implications for the patient. It is proposed that these be included in the regulations of the new Act, rather than in the Act itself, because they are more easily amended as treatment options change.

Urgent treatment

Recommendation 17

That the Mental Health Act authorise urgent psychiatric treatment without tribunal authorisation when treatment is needed urgently to prevent imminent harm, or behaviour likely to cause immediate or imminent harm to the person or other persons, and where authorisation is provided by the Chief Psychiatrist or delegates.

Current position

In emergency situations, Section 40 of the *Guardianship and Administration Act 1995* allows urgent treatment to be provided when a person is incapable of giving consent in order to save the person's life, prevent serious damage to health or prevent suffering, significant pain or distress. This treatment may be authorised by a medical practitioner. There is no requirement that the board be consulted in relation to this treatment.

The forensic provisions of the *Mental Health Act 1996* provide that the Chief Forensic Psychiatrist can authorise urgent treatment.

Consultation response

This issue was not addressed in the Issues Paper or in consultation responses, but has arisen as a result of discussion in relation to involuntary treatment.

Rationale for Recommendation 17

The rationale for including provision for urgent treatment (ie without the authorisation of an independent tribunal) is that there are situations in which delaying treatment will result in harm to the person or other people.

The key elements of this provision for urgent treatment are adopted from the Model Mental Health Legislation. The word "urgent" has been omitted from Part i) of the Model Mental Health Legislation provision because it is repetitive and unnecessary.

The current Tasmanian provision to allow emergency treatment of persons with capacity to make an informed consent is extended to provide for the situation in which the person is a danger to others and is refusing treatment.

The recommendation that urgent treatment could only be authorised by the Chief Psychiatrist or delegates is made on the basis that a stronger safeguard is required than the current situation, in which approval may be provided by a medical practitioner. It is proposed that this power only be delegated to a medical officer with recognised expertise in the field of psychiatry.

Information requirements

Recommendation 18

That at each stage of involuntary assessment and treatment, the rights information sheet (which will include detailed information in relation to the person's rights, the reasons the person meets/or does not meet the criteria for involuntary treatment and any relevant diagnosis) will need to have been provided to the patient, signed by the doctor, and a copy included in the client file with the file note.

Current position

The *Mental Health Act 1996* 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 the person responsible.

In addition, people must be given a statement of their diagnosis and treatment when they have 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.

Consultation response

Feedback provided during the consultation period suggested that generally consumers are not being provided with a statement of their diagnosis and treatment when they have been determined.

Rationale for Recommendation 18

That it is fundamental that a person be informed of their rights at each stage of the process and that it be formally recorded that this information was provided. This process should ensure that information is provided to all persons who may be subjected to involuntary orders.

It is proposed that this same information be provided to carers and immediate family once an order is made (see Family, carers and person responsible, p. 45), if it is deemed to be in the best interests of the person.

Informed consent

Recommendation 19

That further investigation be undertaken about retaining the existing provisions in Section 5AA in relation to informed consent.

Recommendation 20

That the Chief Psychiatrist make standing orders ensuring that, at the time that consent to treatment is sought, doctors provide to patients an information sheet about patient rights and make a note in the client file that the nature and effect of the treatment has been explained to the person and that they have clearly consented to it.

In relation to people subject to a Treatment Order, the rights information sheet will need to have been signed by the doctor and a copy included in the client file with the file note.

Recommendation 21

That further consideration be given to whether people who require treatment and lack capacity to consent should be placed on an involuntary order, regardless of agreement to treatment.

Current position

Section 5AA of the *Mental Health Act 1996* provides that before a valid consent can be given, a medical practitioner must be satisfied that the person is mentally capable of understanding the general nature and effect of the proposed treatment, give the person a clear and full explanation of the treatment including any risks, provide the person with a description of any alternative treatments available (including the risks and advantages of these), clearly answer any questions and allow an opportunity to access independent medical advice. The person must freely and voluntarily consent to the treatment and not withdraw this 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.

Consultation response

Some responses indicated that medical practitioners did not always seek informed consent, but assumed consent in the absence of refusal. The following proposals were made in order to address this situation.

- Implementation of a Consent to Treatment form detailing any proposed treatment and likely effects, signed by the medical practitioner and the patient, and including a statement that the consent to treatment is given voluntarily.
- Provision should be made for recording of consent to treatment for those patients who cannot read or write or who have limited understanding of English.

- In instances when consent is sought and it is believed the person with mental illness lacks capacity, there should be an assessment of capacity which is to be carried out by two psychiatrists.

Rationale for Recommendations 19 & 20

The existing criteria in the *Mental Health Act 1996* provide comprehensive protection in relation to informed consent with the exception that there is no requirement to document that an informed consent has been provided. It is anticipated that the requirement that rights information sheets be provided and documentation made in relation to consent would assist in ensuring that informed consent is provided.

The Drafting Committee is currently considering Recommendation 19 in light of a proposal that the Mental Health Act should only legislate with regard to involuntary treatment. This proposal is in line with some other Australian states (eg New South Wales) that do not refer to the requirements for voluntary treatment, except in relation to electro-convulsive therapy and psychosurgery. The issue of consent to treatment is dealt with, as in other medical situations, under Common Law and does not need to be altered or re-stated in the Mental Health Act.

An alternative view is that it is important that this provision remains in the Mental Health Act because the capacity of the person to understand the nature and effect of the proposed treatment will often be a problem when treatment is considered for a mental illness. According to this view, if the informed consent provisions – including the need for capacity to be established before a consent can be considered valid – are removed, there is a real danger that people will agree to treatment without understanding what they have agreed to, and because there is no order in place, there will be no review by an independent tribunal (see also Recommendation 27b).

Rationale for Recommendation 21

There are divergent views about whether people with a mental illness who lack capacity to provide informed consent should be placed on involuntary orders, regardless of whether they agree to treatment or not. One view is that to place a person on an involuntary order is to choose the most restrictive option, resulting in unnecessary stress and stigma. It is also suggested that this unnecessary demonstration of the clinician's power over the client may seriously damage the therapeutic relationship with negative implications for the ability of the client and case manager to work effectively together in the future.

An alternative view is that allowing people who lack capacity to make informed decisions about their treatment and to agree to treatment without any independent review is dangerous and contrary to common law principles of informed consent that apply in any medical situation (ie that for a consent to treatment to be valid, the person must be able to understand the nature and effect of the treatment). It is suggested that assessment of capacity is a clinical judgement which clinicians are called upon to make regularly within the current legislative framework, and therefore the inclusion of this criteria places no additional burden on clinicians.

Leave of absence

Recommendation 22

That with the introduction of a single Treatment Order covering hospital and community settings, the concept of extended leave be removed from the Act and simplified provisions for short leave be included.

Current position

Currently Community Care Orders have leave of absence provisions for long and short leave. 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.

The Mental Health Tribunal must be notified of a leave of absence every time the person is granted leave, including, for example, situations when the person is simply permitted to go for a short walk while accompanied.

Consultation response

Responses that addressed this issue agreed that leave provisions should be simplified.

Rationale for Recommendation 22

Recommendation 22 provides for the simplification of the leave process and is the logical consequence of having a single order that covers in-patient and community settings. The concept of extended leave will be replaced by a change to the conditions of the order that the person will no longer be residing in an in-patient setting. The concept of short leave will be replaced by a note in the conditions of the order allowing short leave. Some form of notification will need to be provided, but will not be regarded as leave from the order.

Definition of Mental Illness

Recommendation 23

It is recommended that the definition of mental illness contain the following elements:

- *A person has a mental illness if the person suffers, either temporarily or on a continuing basis, from a serious impairment of thought (which may include delusions), mood, volition, perception or cognition.*
- *A diagnosis of mental illness may not be based solely on:*
 - (a) a person's political, religious, or cultural beliefs;*
 - (b) a person's sexual preferences;*
 - (c) a person's criminal or anti-social behaviour;*
 - (d) substance abuse;*
 - (e) intellectual disability;*
 - (f) acquired brain damage;*
 - (g) dementia.*

Current position

To use the powers in the Act that relate to involuntary orders, 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.

Currently the definition of mental illness is as follows:

A mental illness is a mental condition resulting in:

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

A diagnosis of mental illness may not be based solely on:

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

Consultation response

Some issues raised about the current definition of mental illness in the *Mental Health Act 1996* include:

- Concern that the exclusion in relation to intoxication was being used to refuse admission to people who were intoxicated, rather than allowing them to be admitted for observation and assessment.
- Concern that the definition did not extend to personality disorders.
- Concern that people who were suicidal could not be admitted on the basis of this definition.
- Examples of ACT and Northern Territory legislation were provided whereby additional categories of “mental disorder” or “mental dysfunction” were included in the legislation, allowing admission based on a temporary mental condition that fulfils criteria of a mental illness under the legislation.
- Concern that the definition was readily applicable to other illnesses not usually considered mental illnesses, such as dementia or acquired brain injury.
- Concern that the words “involuntary behaviour or serious impairment of the capacity to control behaviour” meant that issues such as uncontrollable anger would need to be addressed.

Rationale for Recommendation 23

The elements of this definition are drawn from the definitions to be found in the Model Mental Health Legislation and the New Zealand *Mental Health (Compulsory Assessment and Treatment) Act 1992*.

These elements are similar to those in the current Act, but it is suggested that the proposed definition provides greater clarity and should be easier to apply. It should be noted that the words “substance abuse” are intended to include intoxication. The recommended definition is also in accordance with the Report *Application of Rights Analysis Instrument to Australian Mental Health Legislation* which proposes that the following factors should be excluded by law from being determinative of mental illness: political status; economic status; social status; membership of a cultural, religious or racial group; moral non-conformity; and reasons not relevant to mental health status, such as sexual orientation³.

It may be argued that the words “either temporarily or on a continuing basis” do not add to the definition, but these have been included with the intention that it is clear to people reading the Act that temporary conditions (such an individual episode of psychosis) are a legitimate basis for admission for assessment.

The additional exclusion criteria relating to acquired brain injury and dementia have been included to clarify that Mental Health Act orders are not appropriate for these conditions.

³ Watchirs, H, 2000

Voluntary and involuntary treatment

Admission

Recommendation 24

That the Mental Health Act requires that entry to an in-patient facility as an involuntary patient will only be as a result of an order under the Mental Health Act. This provision will apply to persons subject to a guardianship order irrespective of the guardian's approval of admission.

Recommendation 25

That all other provisions in relation to voluntary admissions be retained in the Mental Health Act.

Current position

Confusion exists between the provisions of the *Guardianship and Administration Act 1995* and the *Mental Health Act 1996* with respect to voluntary admission. If the Guardianship and Administration Board determines a person does not have capacity and appoints a guardian, and the guardian decides that the person must stay in hospital, it is not clearly articulated whether the admission is voluntary or involuntary, which results in inconsistent interpretation.

Consultation response

Consultation feedback strongly supported the suggestion that if a person lacks capacity to consent to admission to an approved hospital, and is subject to a Guardianship Order, the person must be deemed to be an involuntary patient and an order under the *Mental Health Act 1996* is required.

Rationale for Recommendations 24 & 25

For a person to be voluntarily admitted to an approved hospital requires the person to agree to admission of their own free will and as a consequence of informed consent. This by its very nature precludes situations in which a guardian has provided substitute consent. The Model Mental Health Legislation supports that a person who consents to a voluntary admission must be capable of giving informed consent to that admission.

Refusal of admission

Recommendation 26

- a) *That all refusals of admission to approved hospitals be recorded. That this record includes the reasons for refusal, that the person has been advised of the reasons for refusal and their right to have the matter referred to an approved medical practitioner for a second opinion.*
- b) *That all records of refusal of admission be provided to the Chief Psychiatrist for review.*
- c) *That the Chief Psychiatrist reports on refusals to admit in his or her annual report.*

Current position

Under Section 20 of the *Mental Health Act 1996*, if a medical practitioner refuses a request for admission as a voluntary patient, the practitioner is required to:

- a) tell the applicant why the admission is refused;
- b) give the applicant appropriate information about how to obtain the services, if the medical services appropriate to the applicant's case may be available elsewhere; and
- c) advise the applicant of his or her right to have the matter referred to an approved medical practitioner for a second opinion.

Consultation response

A number of responses identified that people were regularly being refused admission. Feedback suggested that this refusal was often inappropriate and was frequently due to the lack of available beds rather than being based on sound medical grounds. The view was expressed that voluntary admissions were often considered as hotel-bed admissions, and therefore not taken seriously by staff at the Department of Emergency Medicine. Concerns were expressed that the *Mental Health Act 1996* seeks to encourage voluntary admissions to approved hospitals, but that this was not being supported by hospital staff.

It was suggested that people were rarely advised of their right to a second opinion, and if a second opinion was sought it was often difficult to obtain. Consequently people often gave up seeking a voluntary hospital admission. It was also suggested there is a belief that registrars are not obliged to offer a second opinion.

It was proposed that there should be records of the number of applications for involuntary assessment, initial orders and voluntary admission. Each approved hospital and assessment centre should provide annually a report to the Minister for Health outlining the number of applications for involuntary assessment, initial orders and voluntary assessments.

Rationale for Recommendations 26 a), b) & c)

Currently records of refusals of admission are not being maintained, so refusal of admissions cannot be monitored effectively. Ensuring that there is a record of all refusals of admission and that these records are provided to the Chief Psychiatrist will allow monitoring and review and subsequent action to address trends in inappropriate refusal of admission. This monitoring and review mechanism will be strengthened by the requirement for the Chief Psychiatrist to report annually on refusals for admission to the Minister for Health and Human Services. It is suggested that the role of monitoring and review of refusals of admission should rest with the Chief Psychiatrist because it will be an internal review/quality assurance process.

Recording the reasons for refusals of admission will provide documentary evidence of discharge of duty of care should such evidence be required by interested parties, such as the person, their family members, independent tribunals and the coroner's court.

Discharge from hospital

Recommendation 27

That a provision similar to Section 23 of the current Mental Health Act 1996, with regard to the assessment of voluntary patients seeking discharge, be retained to allow time for application to an independent tribunal for creation of a Treatment Order.

Current position

The right of a person admitted voluntarily to discharge him- or herself at any time is stated in Section 22 of the *Mental Health Act 1996*. If a person admitted voluntarily seeks to discharge him- 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 determine whether an order should be made for the involuntary hospitalisation of the person (Section 23 of the *Mental Health Act 1996*).

Section 31 of the *Mental Health Act* provides that treatment can only be provided with the informed consent of the patient, or if it is authorised under the *Guardianship and Administration Act 1995*.

Consultation response

Some responses requested the removal of this provision, because it was suggested the provision is used to place people on orders when they seek to discharge themselves from hospital. It was suggested that, if after voluntary admission, a person's mental health deteriorates to the point that they then satisfy the criteria for involuntary admission, a formal order should be made at that time, before waiting until the patient attempts to discharge him- or herself from an approved hospital.

Other responses suggested there was a need to retain this provision to ensure that action could be taken in cases when an order for involuntary admission would be required for people with a mental illness whose mental health had deteriorated to a point that it would not be in their best interests to discharge themselves from hospital.

Rationale for Recommendation 27

Consideration has been given to the argument that the provision should be removed. However, it is important to ensure that voluntary patients, whose mental health deteriorates to a point where they satisfy the criteria for involuntary admission, can be taken into protective custody and an order can be sought from the independent tribunal for involuntary admission.

Power to take person into protective custody

Recommendation 28

That the intention of the provisions contained in the Mental Health Act 1996 regarding protective custody be retained in the Mental Health Act.

Recommendation 29

That the term “protective custody” be defined in the Mental Health Act.

Recommendation 30

That entry of premises by police or authorised officers, for the purpose of taking a person into protective custody under the Mental Health Act, must result in the person receiving a mental health assessment by a medical practitioner.

Recommendation 31

- a) *That experienced mental health clinicians, general practitioners, police officers (including officers at the rank of sergeant and above, or in charge of a station) and delegated ambulance officers be able to be approved as Authorised Officers.*
- b) *That education and training regarding powers and responsibilities under the Mental Health Act be mandatory for all Authorised Officers.*

Recommendation 32

That the Mental Health Act place an onus on Authorised Officers to ensure that police involvement is not requested, if there is a more appropriate and less restrictive option available.

Current position

Sections 15 and 16 of the *Mental Health Act 1996* provide for authorised officers and police officers to take at-risk people into protective custody and transfer them to an assessment centre. The authorised officer or police officer must on reasonable grounds consider that a person has a mental illness and as a consequence that there is a serious risk of harm to the person or to others. In taking a person into protective custody a police officer or an authorised officer can, without a warrant,

enter the premises where the person is considered to be and use reasonable force in transporting them to an assessment centre. The Act also imposes time limits on the protective custody process.

Consultation response

Consultation feedback comprised the following:

- There is a need for the term “protective custody” to be defined.
- Authorised officers need clarity about their authority under Sections 15(2) and 15(3).
- Section 15 of the *Mental Health Act 1996* relating to protective custody requires that a person “has” a mental illness. Section 24 requires that it “appears” that the person has a mental illness for the purpose of being involuntarily detained. There should be some consistency between the requirements of these provisions.
- The term “assistants” in Section 15(3)(a) of the *Mental Health Act 1996* is unacceptably vague. If the intention of the Act is that the authorised officer may enlist any other person capable of assisting them to control the situation, there needs to be legal protection for the assistant.
- The power conferred in Section 15 of the *Mental Health Act 1996* is clear and necessary.
- Authorised officers should not have to undertake the role of taking someone into protective custody alone except in an extreme emergency.
- Ambulance officers should be included as authorised officers and be provided with relevant training.
- Authorised officers should in general be police officers, because they are accustomed and trained to the situation of enforced entry and control.
- The Act should state clearly that there is an onus on authorised officers to establish a likelihood of violence or dangerousness before police involvement will occur.
- There is potential for police and authorised officers to enter premises, without warrant, under the *Mental Health Act 1996* and without the intention of taking the person into protective custody.
- There should be a warrant or similar authority whereby those empowered by the Act to take someone into protective custody are accountable to the issuer of the authority to demonstrate why they believe the person has a mental illness, and why they believe the person represents significant risk of harm to him- or herself and/or others.
- The current power to enter premises should be preserved. Requiring a “form of approval” to enter premises would delay the process of assessment and treatment and increase the risk of injury or death.
- The protective custody provisions in the Act are the provisions most misunderstood and most subject to abuse. This is because:
 - a) there is no judicial oversight, statutory accountability mechanisms or sanctions for persons empowered to deprive a citizen of their liberty;

- b) there is no statistical mapping of the frequency and circumstances surrounding the use of Section 15 of the *Mental Health Act 1996*; and
 - c) Section 92 of the *Mental Health Act 1996* is perceived by many authorised officers as a blanket personal immunity for all acts or omissions done in the performance of functions under the authority of the Act.
- The Act should reinforce that taking citizens into protective custody is a health issue and not a criminal issue.

Rationale for Recommendation 28

The ability to take a person into protective custody is necessary in the interests of personal and community safety. The protective custody provisions enable a fast response in situations in which the persons with mental illness are considered to be a danger to themselves or others. Section 15 of the current Act seeks to ensure that the civil liberties of a person are not infringed unnecessarily with the requirement that a police officer or authorised officer considers on reasonable grounds that the person has a mental illness and as a consequence there is a serious risk of harm to the person or others. This criterion contained in the current act is stricter than other jurisdictions⁴. To remove or limit the current provisions would reduce the capacity to respond quickly and would increase the risk of injury or death.

Retaining the provisions of protective custody in the Tasmanian Mental Health Act is consistent with all Australian jurisdictions⁵ and is also supported in the Model Mental Health Legislation.

Rationale for Recommendation 29

A definition of protective custody would assist in providing clarity and consistency in relation to protective custody provisions.

Rationale for Recommendation 30

The recommendation has been made with a view to ensuring that the provisions of protective custody are carried out only for the purpose of taking a person with mental illness to be assessed in the interests of personal and community safety.

Rationale for Recommendation 31 a)

Currently mental health clinicians, general practitioners and police officers of a certain rank are authorised officers. Considerable support was provided during the Issues Paper consultation for ambulance officers to be included as authorised officers. Circumstances may require that a person

⁴ ACT *Mental Health (Treatment and Care) Act 1994*, Northern Territory *Mental Health and Related Services Act 1998*, Victorian *Mental Health Act 1986*

⁵ New South Wales *Mental Health Bill 2007*, Northern Territory of Australia *Mental Health and Related Services Act 1998*, Australian Capital Territory *Mental Health (Treatment and Care) Act 1994*, Victorian *Mental Health Act 1986*, Queensland *Mental Health Act 2000*, Western Australian *Mental Health Act 1996*, South Australian *Mental Health Act 1993*

with mental illness who is taken into protective custody has to be transported to an assessment centre by ambulance officers. Currently if this occurs an authorised officer or police officer is required to accompany the person in the ambulance. This presents difficulty, particularly in rural areas, where police resources may be limited to two police officers, or where there are no available authorised officers. Enabling ambulance officers of a specific delegation to be approved as authorised officers would also increase the capacity to provide a health response, so that police officers would only need to be involved when a person was considered to be dangerous or violent.

The inclusion of ambulance officers as authorised officers is consistent with other jurisdictions. Other jurisdictions provide for ambulance officers to have an active role in detaining a person for the purpose of transferring the person to a mental health facility for assessment (eg Northern Territory of Australia *Mental Health and Related Services Act 1998*, New South Wales *Mental Health Bill 2007* and the Model Mental Health Legislation).

Rationale for Recommendation 31 b)

Education and training needs to be mandatory to ensure that authorised officers can use their powers and undertake their responsibilities in accordance with the legislative requirements.

Rational for Recommendation 32

This recommendation is consistent with a health response, the principles of least restrictive treatment and minimum interference with civil liberties.

Family carers and person responsible

Recommendation 33

That the term “person responsible” and role of the person responsible not be retained in the Mental Health Act. (see also Recommendations 5 & 6).

Recommendation 34

That there be a presumption in the Mental Health Act that family members, carers or persons of significance will be informed of any orders imposed and treatment proposed (through a copy of the treatment plan), unless it is determined that this would be contrary to the patient’s best interests for this to occur. The best interests of the patient are to be informed by the patient’s wishes.

(It is proposed that these provisions will override the Personal Information Protection Act 2004.)

Current position

Currently under the *Mental Health Act 1996* the person responsible can apply for a person to be involuntarily admitted (s. 25) and the Act also provides that 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 (s. 45).

As noted in relation to Recommendations 5 and 6, the *Guardianship and Administration Act 1995* provides that a person responsible can consent to medical treatment for a person who lacks capacity to consent (s. 43).

Consultation response

The following issues emerged during the Issues Paper consultation (see also Recommendations 5 and 6 in relation to consent to medical treatment by the person responsible):

- The role of person responsible places undue pressure on the person responsible, particularly when the person responsible is a family member/carer and there is potential to harm the relationship with the person with mental illness.
- Concerns were expressed about the ability of family members to initiate involuntary orders in response to family disputes.
- There is confusion regarding the concept of person responsible and how it sits with the provisions of the *Guardianship and Administration Act 1995*.
- The concept of person responsible under the *Mental Health Act 1996* is not being interpreted appropriately.
- Family and carers who are significantly involved in the life of the mentally ill person are not appropriately engaged as an active party in the treatment and care of the individual

concerned, and are not provided with appropriate information to enable them to support the person in their recovery.

- The privacy legislation is often used to deny carers, family members and significant others access to information regarding the person with a mental illness, despite the person seeking information being a “person responsible”.
- Consumers are concerned about being involuntarily detained at the whim of a spouse, carer, family member or friend.
- Spouses, carers, friends and relatives should not be placed in the position of having to make judgments for which they are not qualified.
- The person responsible should only be able to seek a medical assessment and not make application for an involuntary admission.
- People with mental illness should have the right to nominate their person responsible.

Rationale for Recommendation 33

As indicated in the discussion in relation to Recommendations 5 & 6, it is proposed that the role of the person responsible in providing consent to psychiatric treatment be removed. The effect of Recommendation 33 is that the ability of the person responsible to apply for the involuntary admission of a person will also be removed.

Recommendation 33 also means that the right of the person responsible to receive information will be removed. However, Recommendation 33 suggests that although the term “person responsible” may be removed, the rights of family members, carers or persons of significance to access information will be retained.

The rationale for the proposed removal of the ability to apply for involuntary admission is that family members and carers sometimes feel pressured to sign as the applicant for an order and that initiating an order has potentially harmful effects for their relationship with the person with a mental illness.

Rationale for Recommendation 34

Principle 6 of the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* states that the “The right of confidentiality of information concerning all persons to whom the present principles apply shall be respected”. In the Report on a Rights Analysis Instrument, for use in Evaluating Mental Health Legislation, the right to confidentiality was given equal weight to other rights⁶. However, it was also acknowledged that there are circumstances which present a need for exceptions to confidentiality and privacy rights.

Recognition of the role that family members, carers and significant others play in the treatment and care of people with mental illness has been provided for in recent legislation. The *New South Wales Mental Health Bill 2007* sets out rights of primary carers to be notified of events affecting the person with mental illness. This includes the right of a primary carer to be notified of a person’s initial

⁶ Watchirs, 2000, p5

detention, absences, transfer to other facilities and medical treatments (Sections 75 and 78 *New South Wales Mental Health Bill 2007*). Section 9 of the Northern Territory's *Mental Health and Related Services Amendment Act 2007* has included provisions for the consultation and involvement of family members and carers in the person's treatment and care as far as practicable and appropriate.

Model Mental Health Legislation provides for the provision of information relevant to ongoing care and or treatment to a relative or other person who is considered to be closely involved in ongoing care and/or treatment of the person when disclosure is considered to be in the person's best interests (s150).

It is accepted that there is a significant argument for ensuring the right of confidentiality for people with mental illness. However, it is considered that family members, carers and significant others play a very significant role in caring for and supporting people with a mental illness and need to be provided with sufficient information to be able to satisfactorily carry out these roles. At the same time, it is recognised that circumstances exist when it is not appropriate for family members, carers or significant others to be informed.

The recommendation is formulated in response to consultation feedback and is based on the provisions of the *New Zealand Mental Health (Compulsory Assessment and Treatment) Act 1992*. The aim of the New Zealand legislation is to ensure that family members, carers and significant others are informed of the treatment of the person with mental illness if it is in the best interests of the person. The best interests of the person are informed by the wishes of the person as well as the clinical judgment of the treating medical practitioner.

The provision is considered to provide an appropriate balance between maintaining the confidentiality of the person and engaging with family members, carers or significant others in the interests of providing the best possible treatment outcomes for the person. The recommendation is also in keeping with the *Tasmanian Consumer and Carer Participation Framework* which recognises the contribution carers make to the recovery of a person with mental illness.

Seclusion and bodily restraint

Recommendation 35

That the restraint and seclusion provisions contained in Sections 34 and 35 of the Mental Health Act 1996 continue in their present form for people admitted involuntarily to approved hospitals or assessment centres.

Recommendation 36

That the restraint and seclusion provisions in the Mental Health Act not be extended to people admitted voluntarily to approved hospitals or assessment centres.

Recommendation 37

That the Mental Health Act provides for the restraint of people on Treatment Orders in the community when the restraint is necessary to provide involuntary treatment, or to escort a person for admission to an approved hospital or assessment centre, and that restraint occurs in a manner which considers the health and safety of the person with mental illness, clinicians and the community.

Recommendation 38

That provision be made in the Mental Health Act for the Chief Psychiatrist to issue standing orders in relation to restraint.

Recommendation 39

That provision be made in the Mental Health Act:

- *for the Independent Tribunal and the Chief Psychiatrist to monitor all reports in relation to the use of restraint and seclusion; and*
- *to allow people subjected to restraint and seclusion to request that instances of seclusion and restraint be reviewed by the Independent Tribunal and/or by the Chief Psychiatrist.*

Current position

The criteria that must be satisfied for lawful exercise of seclusion and restraint are set out in Sections 34 and 35 of the *Mental Health Act 1996*. In relation to physical restraint the Act states that an involuntary patient in an approved hospital may be placed under bodily restraint only if the restraint is necessary for medical treatment of the patient; or to prevent injury to the patient or to others; or to prevent the patient from persistently destroying property. The Act states that restraint must be authorised by a medical practitioner or an approved psychiatric nurse for a period of less than four hours and is applied for no longer than authorised.

In relation to seclusion the Act states that an involuntary patient in an approved hospital may be kept in seclusion only if the seclusion is necessary for the protection of the patient or other persons, is authorised by a medical practitioner or an approved psychiatric nurse, and the patient is kept in seclusion no longer than is authorised. During seclusion the patient must be examined every 15

minutes by a nursing staff member and be examined at intervals of not more than four hours by a medical officer.

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.

The provisions of the *Mental Health Act 1996* with regard to seclusion and restraint only apply to people admitted involuntarily in an approved hospital. There is currently no provision in the *Mental Health Act 1996* to restrain a person who is on a community treatment order.

Consultation response

Feedback was provided as follows:

- There is no immediate redress for people with mental illness who feel they have been inappropriately secluded or restrained other than complaint at some point in the future.
- Reports in relation to restraint and seclusion are received by the Mental Health Tribunal but they are not monitored.
- Voluntary patients should not be restrained or secluded.
- Forced medication of involuntary outpatients in community settings is unacceptable if we are to guarantee all citizens the levels of privacy, dignity and personal security required by contemporary human rights norms.

Rationale for Recommendation 35

In some instances the exercise of seclusion and restraint are required in the treatment and care of people with a mental illness. This is recognised by all jurisdictions within Australia.⁷ The need for seclusion and restraint is also recognised by the Model Mental Health Legislation.

Restraint and seclusion understandably raise concern in ensuring patient rights are protected and abuse of power does not occur. The *Mental Health Act 1996*, however, specifies the circumstances in which seclusion and restraint can be used and how these provisions are to be applied in relation to approvals and medical review during and after seclusion and restraint.

Rationale for Recommendation 36

It was strongly advocated that restraint and seclusion provisions should not be extended to include voluntary patients. The argument was presented that seclusion and restraint are acts to which a person cannot consent and therefore should only apply to involuntary patients. The exclusion of voluntary patients from restraint and seclusion is consistent with other jurisdictions (eg Queensland's *Mental Health Act 2000*) and the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*.

⁷ *New South Wales Mental Health Bill 2007, Northern Territory of Australia Mental Health and Related Services Act 1998, Australian Capital Territory Mental Health (Treatment and Care) Act 1994, Victorian Mental Health Act 1986, Queensland Mental Health Act 2000, Western Australian Mental Health Act 1996, South Australian Mental Health Act 1993.*

Rationale for Recommendation 37

There is understandable concern in relation to persons being restrained in community settings. This recommendation is made on the basis that such restraint should only occur in circumstances where there has been due consideration of patient, clinician and community safety. It is certainly not the intention that people be restrained in unsafe circumstances. However, the definition of bodily restraint in the *Mental Health Act 1996* is significantly broader than other mental health legislation and can include taking a person by the arm. In some instances it may be necessary to take a person by the arm, lead them to a vehicle and transport them to an assessment centre. In doing this the person may be deemed to have been restrained under the current *Mental Health Act 1996*. This recommendation is seeking to address such issues and provide protection for the person with mental illness and treating clinicians.

The ability to be able to restrain people, in appropriate circumstances, after due consideration of the health and safety of the person, treating clinicians and community, will be required if the focus is to shift from police being the first response (a custodial response) to clinicians providing the first response (a health response).

Rationale for Recommendation 38

The *Mental Health Act 1996* specifies the framework for the application of provisions with regard to seclusion and restraint. Nevertheless, there is a need to ensure the criteria are being appropriately interpreted and applied. This is most appropriately achieved by the Chief Psychiatrist undertaking a quality assurance review of the application of the relevant provisions of the Act.

Rationale for Recommendation 39

Consultation in relation to the Issues Paper indicated strong support for an independent body to review seclusion and restraint. The recommendation provides for the Independent Tribunal to play a monitoring role in relation to the use of seclusion and restraint supported by a quality assurance review undertaken by the Chief Psychiatrist.

There was very strong support that people who have been subjected to seclusion and restraint should have the ability to have these matters reviewed by an independent body. This has been supported in the recommendation which would allow the Independent Tribunal to undertake a legal review and the Chief Psychiatrist to undertake a quality assurance review of seclusion and restraint.

Review bodies

Recommendation 40

That an Independent Tribunal makes and reviews all Treatment Orders.

Recommendation 41

That the provisions contained in the Mental Health Act 1996 relating to the Mental Health Tribunal and the Forensic Tribunal be retained as provisions relating to the Independent Tribunal in the Mental Health Act.

Recommendation 42

That the Independent Tribunal should have both a legal member and a medical member with recognised expertise in the field of psychiatry sitting at all hearings.

Recommendation 43

That provision be made in the Mental Health Act for a person to apply to the Independent Tribunal for a statement of reasons for decision within 21 days of the decision. That the Independent Tribunal has 21 days from the date of the request to provide a statement of reasons for the decision.

Recommendation 44

That the Mental Health Act includes a right of appeal, for all parties to proceedings, from the Independent Tribunal to the Supreme Court in relation to questions of law and with the leave of the court in relation to questions of fact.

Recommendation 45

That the independent tribunal dealing with civil mental health matters also has responsibility for review of forensic mental health matters.

Recommendation 46

That there be increased provision for legal representation for people on involuntary orders.

Current position

Currently involuntary orders in relation to admission are made by practitioners and reviewed by the Mental Health Tribunal. Authorisation to treat is provided by the Guardianship and Administration Board.

The expertise of members of the Mental Health Tribunal and the Guardianship and Administration Board is not determined except that members should have appropriate knowledge and experience.

The *Mental Health Act 1996* does not currently provide a right of appeal. There is a right of appeal from the Guardianship and Administration Board to the Supreme Court.

Provision does not currently exist for persons subject to Mental Health Tribunal hearings to be provided with the reasons for decisions made (although in practice the tribunal will provide reasons on request).

Currently the Mental Health Tribunal deals with civil mental health matters and the Forensic Mental Health Tribunal deals with forensic mental health matters.

Tasmania does not provide free legal representation for people who are the subject of Mental Health Tribunal or Forensic Mental Health Tribunal hearings. Advocacy Tasmania operates the Mental Health Representation Scheme which provides free representation for people at Mental Health Tribunal hearings.

Consultation response

Consultation feedback suggested the following:

- Broad support for a single tribunal that makes determinations about treatment and detention in relation to mental illness. A number of responses indicated that this body should be the Mental Health Tribunal. There was also a proposal that this role be undertaken by the Guardianship Board.
- There was significant support for the inclusion of both a legal and medical member at all Mental Health Tribunal hearings. Others advocated ensuring that a community member was part of the hearing panel. One response proposed retaining the current position of the tribunal that it has the authority to determine composition of hearing members.
- That decisions should be available, within an appropriate timeframe, and the Act must be amended to reflect this right.
- Strong support for the right of appeal to the Supreme Court from the Mental Health Tribunal.
- General support for combining the Mental Health Tribunal and the Forensic Mental Health Tribunal. Some responses indicated that a separation should remain on the basis that the forensic mental health provisions of the *Mental Health Act 1996* should be separated into another piece of legislation.

Rationale for Recommendation 40

This recommendation is in accordance with Principle 17 of the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* which states the review body for involuntary patients shall be a judicial or other independent and impartial body.

It has yet to be determined which is the most appropriate body to perform the role of independent tribunal. Some of the options include:

- the Mental Health Tribunal
- the Guardianship Board
- a broader combined tribunal
- the Administrative Decisions Tribunal.

Rationale for Recommendation 41

It has been recommended that the Mental Health Tribunal and the Forensic Mental Health Tribunal be combined to form one independent tribunal. As such, the provisions of the *Mental Health Act 1996* will need to be retained and applied to the Independent Tribunal.

Rationale for Recommendation 42

The role of the Independent Tribunal in making treatment orders will make it necessary for a legal member and medical member to be present at all hearings to ensure that the tribunal is appropriately informed in relation to rights and treatment issues.

Other jurisdictions specify composition of members to sit at hearings. Victorian and New South Wales legislation require legal and psychiatric expertise on their equivalent of the tribunal.

Rationale for Recommendation 43

As a legal principle reasons for decisions should be available to the person concerned unless there are public safety concerns or concerns that it may not be in the person's best interest to have access to the reasons for decisions.

Rationale for Recommendation 44

It is generally an accepted legal practice that there is a right of appeal to a higher jurisdiction. This provides greater protection for the rights of people appearing before the tribunal and allows for contentious points of law to be clarified. In this case it is anticipated that this appeal, when granted, will result in a preliminary hearing by the Supreme Court to determine the reasons for the appeal. This is an informal hearing in which parties who are representing themselves (ie without a lawyer) are given every assistance by the court to establish their case. It is anticipated that legal representation would be available for these appeals.

Rationale for Recommendation 45

A single independent tribunal that oversees both civil and forensic mental health matters would provide more effective and efficient use of resources, which should ultimately provide a better quality of review for people with a mental illness.

Rationale for Recommendation 46

Tasmania is one of the few jurisdictions in Australia that does not provide legal representation for people appearing before a Mental Health Tribunal or similar body. Such representation will be become increasingly important before a tribunal which will be making and reviewing orders in relation to involuntary treatment.

The Tasmanian Government has recently provided funding to the Legal Aid Commission of Tasmania to provide representation for people appearing before the Mental Health Tribunal. This will be in addition to the representation currently provided by Advocacy Tasmania's Mental Health Tribunal Representation Scheme. The Legal Aid Commission is currently developing a model of representation to be delivered.

Official visitors

Recommendation 47

That the Official Visitors Scheme be administered independently of Mental Health Services.

Recommendation 48

That the provisions of the current Mental Health Act 1996 relating to official visitors be retained.

Recommendation 49

That the Mental Health Act provides capacity for the official visitors to have a role in the monitoring of services and treatment for all government-funded mental health services.

Recommendation 50

That the Mental Health Act provides for official visitors to have access to any ward in an approved hospital where a person is being treated for a mental illness.

Recommendation 51

That the Mental Health Act not be amended to provide for official visitors to have access to documents deemed to have privilege under Section 4 of the Health Act 1997.

Current position

Official visitors are currently funded and administered by Mental Health Services.

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.

Official visitors currently only monitor services and treatment of approved hospitals and not community sector non-government organisations.

Official visitors do not currently have access to people with mental illness in other wards in approved hospitals.

Consultation response

Generally there was overwhelming support for official visitors to:

- have access to people with mental illness who are on other surgical or general wards;
- have access to all documentation including incident reports; and
- have a role in the monitoring of services and treatment for all government-funded programs.

A smaller number of responses asserted there were already professional bodies for each discipline of clinical staff: professional privileges committees, registration authorities, a Health Complaints Commissioner, an Ombudsman, hospital complaints system, quality assurance officers and various non-government advocacies. Therefore it was difficult to see why such a service as the official visitors should attract funds that could be better deployed elsewhere. It was further argued that few lay people were capable of authoritatively undertaking the requirements of Sections 75(a) or (c) as provided in the *Mental Health Act 1996*.

Rationale for Recommendation 47

It is considered that the monitoring and investigative role of the Official Visitors Scheme should be undertaken within an administrative structure that is independent of Mental Health Services. Some options which may be explored with key stakeholders are that the official visitors become a statutory independent body (like the Office of the Commissioner for Children) or be administered by an independent statutory body, such as the Health Complaints Commission, the Ombudsman's Office, or the Mental Health Tribunal.

Rationale for Recommendation 48

The Official Visitors Scheme was provided for in the *Mental Health Act 1996* following a recommendation for the establishment of such a scheme in the *Burdekin Report* and is considered vital in safeguarding the rights of people with mental illness.

Most other states and territories have an official visitor program in some form whereby official visitors visit mental health facilities and examine the physical environment and care of people with mental illness, as well as investigate suspected breaches of the Act and complaints.⁸

The Official Visitors Scheme is also in keeping with the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* and the *National Mental Health Statement of Rights and Responsibilities*.

Rationale for Recommendation 49

In recognition of the increased role of the non-government sector in providing mental health services, there is a need to expand the role of official visitors to the community sector.

Rationale for Recommendation 50

It is appropriate for official visitors to have access to any ward in an approved hospital where a person is being treated for a mental illness to ensure that these people have access to the same safeguards as those for people with mental illness in other approved hospitals.

⁸ For example: New South Wales *Mental Health Bill 2007* and Northern Territory of Australia *Mental Health and Related Services Act 1998*.

Rationale for Recommendation 51

The legislative provisions contained under the *Health Act 1997* in relation to Quality Assurance Committees clearly state that documents are considered to be privileged documents when they relate to proceedings or are prepared for the purposes of a committee which has been declared a specific committee (quality assurance committee) for the purposes of the Act.

The Act also states that a person who is or has been a member of such a quality assurance committee is not required to produce before any court, tribunal, board, agency or person, any document in the person's possession or under the person's control or give evidence of any information or document relating to the proceedings, or prepared for the purposes, of a committee deemed to be a quality assurance committee under the *Health Act 1997*.

Section 4 of the *Health Act 1997* was enacted to provide statutory immunity from any obligation of disclosure for participants on prescribed quality assurance committees. Statutory immunity enables quality matters to be analysed and discussed without the risk of inappropriate disclosure of information that is obtained in the course of the approved committee performing its functions and facilitating improvements in practice for the benefit of Tasmanian health services users. The aim is to provide a level of confidence and security to encourage health care providers and managers to communicate openly and honestly with their colleagues in assessing the management, process and outcomes of health care practices.

Chief Psychiatrist

Recommendation 52

That the position of Chief Psychiatrist be created under the Mental Health Act.

Recommendation 53

That the Mental Health Act makes provision for the Chief Psychiatrist to receive copies of all reports provided to the Independent Tribunal and that the Chief Psychiatrist has the power to inquire into any matters contained in these reports.

Recommendation 54

That the Independent Tribunal has the power to request reports from the Chief Psychiatrist in relation to matters of concern.

Recommendation 55

That none of the functions of approved medical practitioners under the current Mental Health Act 1996 be transferred to the Chief Psychiatrist.

Recommendation 56

That the Chief Psychiatrist has power under the Mental Health Act to:

- *inquire into the practice of other practitioners;*
- *authorise treatment in urgent circumstances; and*
- *make standing orders.*

Current position

Currently the *Mental Health Act 1996* provides for the statutory position of Chief Forensic Psychiatrist, who has powers to make standing orders for:

- the management and security of secure mental health units; and
- the welfare, protection, care, treatment and control of forensic patients and persons subject to supervision orders.

The position of Chief Forensic Psychiatrist also has practical functions under the current legislation, such as authorising detention and treatment for forensic patients in certain urgent circumstances.

The *Mental Health Act 1996* does not make provision for a similar position within non-forensic mental health services.

Consultation response

Varied opinions were expressed in relation to the creation of the position of Chief Psychiatrist:

- It is unnecessary and inappropriate to create a position of Chief Psychiatrist.
- In so far as the position is intended to provide organisational and operational consistency and direction as an internal position, it is to be applauded. This role should not be confused with review functions, except from an internal perspective.
- The creation of the position of Chief Psychiatrist could conceivably provide additional protection to the rights of the mentally ill. The Chief Psychiatrist could conduct investigations in response to issues raised by both patients and official visitors. These currently appear to be undertaken by the Office of the Health Complaints Commissioner. The Chief Psychiatrist could report to the Minister or to the tribunal.
- The Act stipulates the creation of two Chief Psychiatry positions – one for the adult population and one to manage the needs of children in the State. These positions should be granted the necessary clinical governance to ensure that quality mental health care is delivered to those patients whose management falls under the Act.
- This could be a useful position if given adequate independence.
- The Chief Psychiatrist should be able to oversee the operations of approved medical practitioners, but there would be a conflict of interest if the incumbent were to exercise a similar function, except in emergency circumstances.

Consultation feedback focused on the issue of the independence of the Chief Psychiatrist. Some responses were supportive of the Chief Psychiatrist being independent and taking on the role of other current review bodies. Others suggested that the Chief Psychiatrist should not assume the role of other current review bodies, but should play a role of internal review.

Rationale for Recommendation 52

- The position of Chief Psychiatrist or a similar role has been introduced in all Australian jurisdictions. For example, in the Victorian legislation the position of Chief Psychiatrist has responsibility under the Victorian *Mental Health Act 1986* for the medical care and welfare of persons receiving treatment or care for mental illness. Key functions of the Chief Psychiatrist include: investigations concerning treatment-related issues when the Chief Psychiatrist determines such an investigation is warranted.
- State-wide clinical review of approved mental health services to examine the standard, quality and consistency of clinical practice provided.
- Investigation of complaints from consumers and carers.
- Management of enquiries and correspondence from members of the public, service providers and other organisations.
- Development of clinical guidelines and circulars concerning application and interpretation of the Act and establishment and maintenance of practice standards.
- Provision of expert advice and consultation.

The concept of a position of Chief Psychiatrist was also supported by the Model Mental Health Legislation, according to which the Chief Psychiatrist would be “responsible for the medical care and welfare of persons receiving treatment and care at a mental health facility or form a health care agency”.⁹

The concept of a position such as the Chief Psychiatrist is not new to Tasmania. Amendments to the *Mental Health Act 1996* implemented in 2006 introduced the position of Chief Forensic Psychiatrist. In practice the Chief Forensic Psychiatrist has general medico legal responsibility for the care of forensic patients and people on supervision orders and the operation of secure mental health units. This includes admission, discharge and leave of forensic patients and involuntary patients, their care and treatment, and the general functioning of secure mental health units. There are also specific responsibilities with respect to advice to courts, reports, transfers and security. This position has provided an important internal review role in relation to forensic mental health patients. This position has not been an additional impost on resources; instead it has played a valuable oversight and quality assurance role. The current review seeks to replicate this in civil mental health services.

The creation of the position of Chief Psychiatrist would be in keeping with national jurisdictions and Model Mental Health Legislation. It is envisaged that creating the position of Chief Psychiatrist under a new Mental Health Act would be for the purpose of providing an internal review role, particularly in relation to clinical practice in providing Mental Health Services. It is not intended to take powers away from existing review bodies and give these powers to the Chief Psychiatrist. This position

⁹ Commonwealth Department of Human Services and Health, *Model Mental Health Legislation*, Canberra, 1995, p. 303.

would be an additional safeguard which would play a primary role of internal review and, importantly, quality assurance with regard to clinical practice.

Rationale for Recommendations 53 & 54

In undertaking a quality assurance and internal review it would be appropriate for the Chief Psychiatrist to receive copies of all reports provided to the Independent Tribunal and to have the capacity to inquire into any matters contained in these reports. To assist the Independent Tribunal to undertake their role under the Mental Health Act it is appropriate for the Independent Tribunal to have the power to request reports for the Chief Psychiatrist.

Rationale for Recommendation 55

The Chief Psychiatrist will undertake a role of quality assurance and internal review and therefore it is not appropriate for the functions of approved medical practitioners under the current *Mental Health Act 1996* to be transferred to the Chief Psychiatrist.

Rationale for Recommendation 56

A key role of the Chief Psychiatrist will be to monitor clinical practice in accordance with legislative requirements. This will require the ability to inquire into the practice of other practitioners and the ability to make standing orders.

The *Mental Health Act 1996* currently provides for the Chief Forensic Psychiatrist to authorise treatment in urgent circumstances. The recommendation will provide for the Chief Psychiatrist to have the same powers. This recommendation is in accordance with the common law doctrine of urgent and necessary treatment which is available to all medical practitioners and Principle 11 of the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* which supports urgent treatment necessary to prevent immediate or imminent harm to the person or to others.

Miscellaneous

Approved hospitals and assessment centres

Recommendation 57

That the Chief Psychiatrist issue standing orders requiring quality assurance against the criteria for approved hospitals and assessment centres.

Recommendation 58

That the criteria for approved hospitals and assessment centres contained in Section 24 of the Mental Health Act 1996 be retained in the Mental Health Act.

Current position

Section 9 of the *Mental Health Act 1996* provides that the Minister may approve a hospital for the care and treatment of involuntary patients with mental illnesses. Before the Minister approves a hospital, he or she must be satisfied that the hospital is properly equipped and staffed for the care and treatment of involuntary patients with mental illnesses, and that the prospective controlling authority of the hospital is a suitable body or person to be in charge of a place approved for the care and treatment of involuntary patients with mental illnesses. The same criteria are applied to the approval of assessment centres.

Consultation response

There was significant support for criteria for approved hospitals and approved assessment centres. A small number of responses did not support the inclusion of criteria for approved hospitals and assessment centres, because it was believed to be sufficiently specified in Sections 6 (a) and (e) of the *Hospitals Act 1918*.

Rationale for Recommendations 57 & 58

Establishment of the criteria is simply the starting point for an ongoing mechanism to ensure the quality of facilities available for treatment of people with a mental illness. This would be best undertaken by the Chief Psychiatrist issuing standing orders which require quality assurance against the criteria for approved hospitals and assessment centres.

Approval of medical practitioners and authorised officers

Recommendation 59

- a) *That the Chief Psychiatrist establish criteria for the approval of medical practitioners and authorised officers and issue standing orders to enforce the criteria.*
- b) *That education and training in relation to the operation of the Mental Health Act and subsequent powers and responsibilities be mandatory for all approved medical practitioners and authorised officers.*

Current position

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.

Consultation response

Consultation feedback suggested strong support for the establishment of criteria for the approval of medical practitioners and authorised officers in the Mental Health Act and for mandatory education and training for approved medical practitioners and authorised officers in relation to their powers under the legislation and their subsequent responsibilities.

Rationale for Recommendation 59 a)& b)

The recommendation has been made in the interests of establishing appropriate criteria for the approval of medical practitioners and authorised officers and to provide a mechanism for enforcing the criteria. The recommendation also acknowledges the importance of education and training for approved medical practitioners and authorised officer to ensure that they are aware of their powers and responsibilities under the legislation.

Young people

Recommendation 60

That the Mental Health Act requires that the admission of young people to a secure mental health unit be conditional on the capacity to provide the young person with appropriate care and accommodation separately from adults.

Current position

Currently the *Mental Health Act 1996* does not require that the admission of young people to the secure mental health unit be conditional on the capacity to provide the young person with appropriate care and accommodation separately from adults. The Chief Forensic Psychiatrist has, however, issued a standing order which requires that young people can only be admitted to the secure mental health unit if they can be accommodated separately.

Consultation response

There was overwhelming support for young people to be accommodated separately at the secure mental health unit.

Rationale for Recommendation 60

The recommendation is made in response to consultation feedback and in the interests of formalising the Chief Forensic Psychiatrist's standing order that young people are not to be admitted to the secure mental health unit unless they can be accommodated separately. The secure mental health unit has facilities which allow for the separate accommodation of young people without the need to for integration with the broader secure mental health unit community.

Interpreter services

Recommendation 61

That the Mental Health Act provide for the right to an interpreter, in the person's first language, free of charge.

Current position

The *Mental Health Act 1996* does not provide for the right to an interpreter.

Consultation response

There was overwhelming support for the *Mental Health Act* to provide for the right to an interpreter free of charge.

Rationale for Recommendation 61

The recommendation has been made that people shall be informed of their rights as soon as possible after admission, in a form and a language which the patient understands. To ensure this, there is a need for the Act to provide for the right to an interpreter free of charge.

This recommendation is in accordance with the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* and the *National Mental Health Statement of Rights and Responsibilities*.

Practice of religion

Recommendation 62

That the Mental Health Act provide for the right to practice a religion of choice, where practicable, when being involuntarily treated.

Current position

The *Mental Health Act 1996* does not provide for the right to practice religion of choice.

Consultation response

There was overwhelming support for the provision of treatment and care for people with mental illness which enabled the person to practice their religion of choice.

Rationale for Recommendation 62

The recommendation is made in response to consultation feedback and in the interests of facilitating patient rights with regard to practice of religion. The recommendation is also in accordance with the *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* and the *National Mental Health Statement of Rights and Responsibilities*.

Areas not addressed in this Discussion Paper

Provisions of the Mental Health Act 1996

The Discussion Paper does not make recommendations in relation to all sections of the *Mental Health Act 1996*. The focus of the paper is on recommendations which will require significant alteration to current mental health legislation and address issues raised throughout the Issues Paper consultation process. There is, however, a commitment to review all sections of the *Mental Health Act 1996* and an opportunity for consultation on amended provisions will occur during the consultation process for the draft Bill. An opportunity will also be provided during the Discussion Paper consultation process for people to identify other sections of the *Mental Health Act 1996* which need to be considered.

Advance directives

There has been very clear and broad support indicated for the inclusion of advance directives with respect to treatment and provision of information in the Mental Health Act.

Advance directives could operate to allow people with a mental illness, at a time when they have decision making capacity, to record their wishes in relation to what should happen when they may be unwell and lack the capacity to make informed decisions for themselves. Such directives could cover treatment options, who should contribute to treatment planning and who should be informed in relation to the person's condition at a time when they are well.

The Minister for Health and Human Services has indicated that she is supportive of advance directives being available to people with a mental illness. She is also aware, however, that this concept is applicable across the spectrum of health services and that any approach to legislating in this regard should not be undertaken in isolation.

The Minister has proposed that the concept of advance directives not be addressed as part of this review of the Mental Health Act, but should be considered as part of a broader legislative project for the Department of Health and Human Services following this review. Any recommended amendments to the Mental Health Act could be proposed to Parliament as part of this broader project.

Interstate recognition of Community Treatment Orders

Some responses to the Issues Paper indicated the need for interstate recognition of Community Treatment Orders in the *Mental Health Act 1996*. This issue has recently been addressed in amendments made to the *Mental Health Act 1996* in April 2007. These amendments allow for interstate recognition of all involuntary orders where states have entered into Ministerial agreements.

Young people

Significant feedback was provided during the Issues Paper consultation that the legislation should provide for separate accommodation of young people with mental illness, although the Discussion Paper does not make any recommendations in relation to this issue. Current mental health facilities have not been purpose built to allow separate accommodation for young people. A substantial budget allocation would be required to modify the current facilities or to build a dedicated unit for young people. Currently the only facility in Tasmania which has the capacity to provide separate accommodation for young people is the Secure Mental Health Unit. However, the unit was purpose built to allow separate accommodation.

The inability to accommodate young people separately in mental health facilities is not peculiar to Tasmania. *The Report to the Australian Health Ministers' Advisory Council Mental Health Working Group on the Application of the Rights Analysis Instrument to Australian Mental Health Legislation* acknowledged that most Australian jurisdictions had difficulty meeting the legislative requirement to provide separate facilities for minors with only two jurisdictions partially fulfilling this criterion. The national panel suggested that there may be more merit in this being an administrative requirement rather than a legislative requirement. All Australian jurisdictions were considered to be in half compliance of the rights indicator in relation to minors by having general child protection legislation and common law recognition of the best interests of the child, as well as a capacity to consent and make decisions that evolved with maturity.

The Tasmanian legislative framework for people with a mental illness

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 1995* 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 1996* 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.

Summary of recommendations

Recommendation 1

- a) *That the objects of the Mental Health Act 1996 be retained.*
- b) *That the objects of the Mental Health Act be broadened to reflect the United Nations Principles on the Care and Protection of People with a Mental Illness and for the Improvement of Mental Health Care, the National Mental Health Policy and Plan, the National Standards for Mental Health Services (encompassing the National Mental Health Statement of Rights and Responsibilities), the Model Mental Health Legislation and the Tasmanian Mental Health Services Consumer and Carer Participation Framework.*
- c) *That the objects of the new Mental Health Act include a focus on human rights.*

Recommendation 2

- a) *That the Mental Health Act include objects of service for Tasmanian Mental Health Services.*
- b) *That the objects of service and the strategic principles of the Tasmania Mental Health Strategic Plan 2006–2011 be consistent.*

Recommendation 3

That the principle of minimum interference with civil rights be retained in the Mental Health Act.

Recommendation 4

That the Mental Health Act include the ability to treat without consent in appropriate circumstances.

Recommendation 5

That the ability of the person responsible to provide substitute consent to psychiatric treatment be removed.

Recommendation 6

That the ability to consent to treatment will, except in urgent circumstances, only be exercised by an independent tribunal.

Recommendation 7

That all issues dealing with the Mental Health Act be dealt with, where possible, by a single tribunal, at one hearing.

Recommendation 8

That application for a Treatment Order and subsequent reports and reviews must include a detailed treatment plan. So far as is possible, the person and unless the person objects, the wishes of those providing ongoing care must be included in the development and the ongoing implementation of the treatment plan.

Recommendation 9

That an Initial Order be renamed an Assessment Order.

Recommendation 10

That a single order, to be referred to as a Treatment Order, deals with all treatment issues including detention. This order will replace the current Continuing Care Order and Community Treatment Order.

Recommendation 11

That the Mental Health Act provides that people subject to a Treatment Order who refuse to comply with their treatment plan may be treated involuntarily in an “approved treatment centre” (which would include an approved hospital).

Recommendation 12

That the primary purpose of a Treatment Order will be to facilitate assertive case management providing for treatment while the person continues to reside in the community.

Recommendation 13

That the model described below (see also Diagram 1) be adopted as the model for authorising treatment, including detention, under the Mental Health Act.

Recommendation 14

That all of the following criteria be met prior to making a Treatment Order:

- *the person appears to be mentally ill;*
- *the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order;*
- *because of the person's mental illness, involuntary treatment of the person is necessary for his or her health, safety or welfare (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; (welfare to include reputation and financial wellbeing); and*
- *the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.*
- *That there be further consideration as to whether the following be included as part of the criteria for a Treatment Order:*
- *the person has unreasonably refused or is unable to consent to the necessary treatment for the mental illness.*

Recommendation 15

That the definition of Treatment:

- *includes detention; and*
- *refers to professional intervention to remedy the mental illness; or lessen its ill effects or the pain and suffering which it causes.*

Recommendation 16

That regulations be created determining processes for particular treatment that are considered to present higher risks (eg Electro-Convulsive Therapy and Psychosurgery).

Recommendation 17

That the Mental Health Act authorise urgent psychiatric treatment without tribunal authorisation when treatment is needed urgently to prevent imminent harm, or behaviour likely to cause immediate or imminent harm, to the person or to other persons, and where authorisation is provided by the Chief Psychiatrist or delegates.

Recommendation 18

That at each stage of involuntary assessment and treatment, the rights information sheet (which will include detailed information in relation to the person's rights, the reasons the person meets or does not meet the criteria for involuntary treatment and any relevant diagnosis) will need to have been provided to the patient, signed by the doctor and a copy included in the client file with the file note.

Recommendation 19

That further investigation is undertaken about retaining the existing provisions in Section 5AA in relation to informed consent.

Recommendation 20

That the Chief Psychiatrist makes standing orders ensuring that at the time that consent to treatment is sought doctors provide to patients an information sheet about patient rights and make a note in the client file that the nature and effect of the treatment has been explained to the person and that they have clearly consented to it.

In relation to people subject to a Treatment Order, the rights information sheet will need to have been signed by the doctor and a copy included in the client file with the file note.

Recommendation 21

That further consideration be given whether people who require treatment and lack capacity to consent should be placed on an involuntary order regardless of agreement to treatment.

Recommendation 22

That with the introduction of a single Treatment Order covering hospital and community settings, the concept of extended leave be removed from the Act and simplified provisions for short leave be included.

Recommendation 23

It is recommended that the definition of mental illness contain the following elements:

- *A person has a mental illness if the person suffers, either temporarily or on a continuing basis, from a serious impairment of thought (which may include delusions), mood, volition, perception or cognition.*
- *A diagnosis of mental illness may not be based solely on:*
 - a) *a person's political, religious, or cultural beliefs;*
 - b) *a person's sexual preferences;*
 - c) *a person's criminal or anti-social behaviour;*
 - d) *substance abuse;*
 - e) *intellectual disability;*
 - f) *acquired brain damage;*
 - g) *dementia.*

Recommendation 24

That the Mental Health Act requires that entry to an inpatient facility as an involuntary patient will only be as a result of an order. This provision will apply to persons subject to a guardianship order irrespective of the guardian's approval of admission.

Recommendation 25

That all other provisions in relation to voluntary admissions be retained in the Mental Health Act.

Recommendation 26

- a) *That all refusals of admission to approved hospitals be recorded. That this record should include the reasons for refusal and that the person has been advised of the reasons for refusal and their right to have the matter referred to an approved medical practitioner for a second opinion.*
- b) *That all records of refusal of admission be provided to the Chief Psychiatrist for review.*
- c) *That the Chief Psychiatrist reports on refusals to admit in his or her annual report to the Minister for Health and Human Services.*

Recommendation 27

That a provision similar to Section 23 of the current Mental Health Act 1996, with regard to the assessment of voluntary patients seeking discharge, be retained to allow time for application to an independent tribunal for creation of a treatment order.

Recommendation 28

- a) That the intention of the provisions contained in the Mental Health Act 1996 regarding protective custody be retained in the Mental Health Act.*
- b) That drafting of the provisions be reviewed to ensure consistency and clarity.*

Recommendation 29

That the term “protective custody” be defined in the Mental Health Act.

Recommendation 30

That entry of premises by police or authorised officers, for the purpose of taking a person into protective custody under the Mental Health Act, must result in the person receiving a mental health assessment by a medical practitioner.

Recommendation 31

- a) That experienced mental health clinicians, general practitioners, police officers (including officers at the rank of sergeant and above or officers in charge of a station) and delegated ambulance officers be able to be approved as Authorised Officers.*
- b) That education and training regarding powers and responsibilities under the Mental Health Act be mandatory for all Authorised Officers.*

Recommendation 32

That the Mental Health Act place an onus on Authorised Officers to ensure police involvement is not requested if there is a more appropriate and less restrictive option available.

Recommendation 33

That the term “person responsible” and role of the person responsible not be retained in the Mental Health Act (see also Recommendations 5 & 6).

Recommendation 34

That there be a presumption in the Mental Health Act that family members/carers or persons of significance will be informed of any orders imposed and treatment proposed (through a copy of the treatment plan) unless it is determined that this would be contrary to the patient's best interests for this to occur. The best interests of the patient are to be informed by the patient's wishes.

(It is proposed that these provisions will override the Personal Information Protection Act 2004.)

Recommendation 35

That the restraint and seclusion provisions contained in Sections 34 and 35 of the Mental Health Act 1996 continue in their present form for people admitted involuntarily to approved hospitals or assessment centres.

Recommendation 36

That the restraint and seclusion provisions in the Mental Health Act not be extended to people admitted voluntarily to approved hospitals or assessment centres.

Recommendation 37

That the Mental Health Act provide for the restraint of people on Treatment Orders in the community when the restraint is necessary to provide involuntary treatment or to escort a person for admission to an approved hospital or assessment centre and restraint occurs in a manner which considers the health and safety of the person with mental illness, treating clinicians and the community.

Recommendation 38

That provision is made in the Mental Health Act for the Chief Psychiatrist to issue standing orders in relation to restraint.

Recommendation 39

That provision is made in the Mental Health Act:

- *for the Independent Tribunal and the Chief Psychiatrist to monitor all reports in relation to the use of restraint and seclusion; and*
- *to allow people subjected to restraint and seclusion to request that instances of seclusion and restraint be reviewed by the Independent Tribunal and/or by the Chief Psychiatrist.*

Recommendation 40

That an Independent Tribunal makes and reviews all Treatment Orders.

Recommendation 41

That the provisions contained in the Mental Health Act 1996 relating to the Mental Health Tribunal and the Forensic Tribunal be retained as provisions relating to the Independent Tribunal in the Mental Health Act.

Recommendation 42

That the Independent Tribunal has both a legal member and a medical member with recognised expertise in the field of psychiatry sitting at all hearings.

Recommendation 43

That provision is made in the Mental Health Act for a person to apply to the Independent Tribunal for a statement of reasons for decision within 21 days of the decision. That the Independent Tribunal has 21 days from the date of the request to provide a statement of reasons for the decision.

Recommendation 44

That the Mental Health Act includes a right of appeal for all parties to proceedings, from the Independent Tribunal to the Supreme Court, in relation to questions of law and with the leave of the court in relation to questions of fact.

Recommendation 45

That the independent tribunal dealing with civil mental health matters also has responsibility for review of forensic mental health matters.

Recommendation 46

That there is increased provision for legal representation for people on involuntary orders.

Recommendation 47

That the Official Visitors Scheme be administered independently of Mental Health Services.

Recommendation 48

That the provisions of the current Mental Health Act 1996 relating to official visitors be retained.

Recommendation 49

That the Mental Health Act provides capacity for the official visitors to have a role in the monitoring of services and treatment of all government-funded mental health services.

Recommendation 50

That the Mental Health Act provides for official visitors to have access to any ward in an approved hospital where a person is being treated for a mental illness.

Recommendation 51

That the Mental Health Act not be amended to provide for the official visitors to have access to documents deemed to have privilege under Section 4 of the Health Act 1997.

Recommendation 52

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That the Mental Health Act provides for the right to an interpreter, in the person's first language, free of charge.

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That the Mental Health Act provides for the right to practice a religion of choice, where practicable, when being involuntarily treated.

Development of this Discussion Paper

This Discussion Paper has been developed by the Mental Health Act Review Drafting Committee with advice and assistance from the Mental Health Act Review Advisory Committee. The recommendations outlined in this paper have been informed by written responses to the Issues Paper and feedback provided at public forums around the State.

Membership of the Mental Health Act Review Drafting Committee

Assoc Professor Des Graham, Director, Mental Health Services (Chair)
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Dr Richard Benjamin, Associate Southern Clinical Director, Mental Health Services South
Dr John Crawshaw, Director, Statewide Specialist Services/Chief Forensic Psychiatrist
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Brian Stokes, Acting Manager Coordination and Innovation, Mental Health Services
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Inspector Mark Mewis, Mental Health Liaison Officer, Tasmania Police
Val Shelton-Bunn, Manager, Official Visitors Scheme
Daryl Lamb, President, Mental Health Council of Tasmania
Ken Hardaker, Manager, Advocacy Tasmania
Assoc Professor Des Graham, Director, Mental Health Services (ex-officio)

Useful resources

Tasmanian law

The following Acts may be viewed in full at <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> http://www.legislation.act.gov.au/
New South Wales	<i>Mental Health Act 1990</i> http://www.legislation.nsw.gov.au/
Northern Territory	<i>Northern Territory Mental Health and Related Services Act 2005</i> http://www.nt.gov.au/dcm/legislation/current.html
Queensland	<i>Mental Health Act 2000</i> http://www.legislation.qld.gov.au/
Victoria	<i>Mental Health Act 1986</i> http://www.mhrb.vic.gov.au/legislation/act.htm
South Australia	<i>Mental Health Act 1993</i> http://www.legislation.sa.gov.au
Western Australia	<i>Mental Health Act 1996</i> http://www.slp.wa.gov.au/statutes/swans.nsf

Publications

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Appendix I: 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*, pp. 10–12: http://www.dhhs.tas.gov.au/agency/pro/mentalhealth/documents/Mental_Health_Full.pdf