Annual Report 2016-2017

Chief Civil Psychiatrist
Chief Forensic Psychiatrist

Mental Health, Alcohol and Drug Directorate
Department of Health and Human Services

Tasmanian Government

Contents

1. Introduction

I am pleased to provide this Annual Report on the Chief Civil Psychiatrist and Chief Forensic Psychiatrist's activities during the 2016-17 Financial Year to the Minister for Health as is required by section 150 of the *Mental Health Act 2013* (the Act).

I have reported on the statutory requirements of the Act and, in addition, have made some observations and presented data regarding the mental health system as a whole in Tasmania.

The Act commenced operation across Tasmania at 12:01am on 17 February, 2014.

The Act, the result of many years of consultation, discussion and planning, brought to Tasmania a relatively new and significant advance in the legislative framework for the treatment of those experiencing mental illness. It represented a major reform in the legal framework for the care and treatment of people with mental illness. Tasmania was the first Australian jurisdiction to have enacted mental health legislation that introduced decision making capacity as a threshold measure that must be considered before a person may be involuntarily assessed or treated. It has, as its foundations, Tasmania's commitment to human rights and to the recovery model of mental health care.

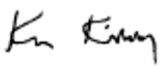
The Act established what is effectively a substitute decision making framework for those who because of their mental illness lack decision making capacity, and cannot make their own assessment and treatment decisions, but who need treatment to prevent harm to their own health or safety or the safety of others. At the same time, it recognises that people who have the capacity to make their own decisions have the right to do so. Decision making capacity becomes the key test for when the *Mental Health Act 2013* may apply. In this manner, the freedom of people to make their own decisions when capable of doing so is preserved.

The Act also enables care and treatment to be given in a timely and appropriate manner, thus ensuring those who are not able to make their own decisions because of mental illness regain decision making ability at the earliest opportunity.

The Act has established reporting requirements which provide for detailed oversight of the workings of the Act and form the bases for the data reported in this Annual Report.

The Act has recently been amended to increase its efficiency of operation and reduce the burden on persons subject to the Act. The amendments were introduced on the 1st July 2017 and will be reported in the 2017-18 Annual report.

I am pleased to present this Annual Report of the Chief Civil Psychiatrist and Chief Forensic Psychiatrist to the Minister.



Professor Ken Kirkby

Acting Chief Psychiatrist

Chief Civil Psychiatrist | Chief Forensic Psychiatrist

2. Objectives

The objectives of this report are to:

- Provide to the Minister information about the Chief Civil Psychiatrist and Chief Forensic Psychiatrist's activities during the 2016-17 Financial Year.
- Contribute to the improvement of standards of care and treatment for people with a mental illness.
- Inform mental health service users, families, carers, service providers and members of the public about the roles, function and activities of the Chief Civil Psychiatrist and Chief Forensic Psychiatrist.

3. Role and Function of the Chief Psychiatrists

The roles of Chief Civil Psychiatrist and Chief Forensic Psychiatrist as provided for under the Act are both undertaken by the incumbent to the State Service role of Chief Psychiatrist. The role of Chief Psychiatrist sits within the Mental Health, Alcohol and Drug Directorate, as part of the Department of Health and Human Services, and is responsible for providing high level specialist advice about mental health policy and clinical practice to the Minister, across the Department, to the Tasmanian Health Service and to other operating units as appropriate.

Broadly speaking, the functions of the Chief Psychiatrist fall into the following domains:

i. Legislative and policy
ii. Strategic quality improvement
iii. Reform
iv. Information and clinical performance

The Chief Psychiatrists have a general overall responsibility, under and to the Minister for Health, for ensuring that the objects of the Act are met in respect of relevant patients and for the running of approved facilities.

To do this, the Chief Psychiatrists undertake a range of functions including approving forms for use under relevant provisions of the Act, issuing Standing Orders and Clinical Guidelines under sections 151 and 152 of the Act and intervening directly with regard to the assessment, treatment and care of patients with respect to prescribed matters under section 147 of the Act.

The Chief Psychiatrists have a particular role regarding seclusion, restraint, the use of force, leave decisions, visiting, correspondence and telephone rights and assessment and treatment generally, and may issue consequential directions for the future assessment, treatment and care of patients.

The Chief Psychiatrists also have statutory responsibility for the transfer of patients to secure institutions or approved facilities, and for appointing people to perform particular statutory roles under the Act.

4. Statutory Roles

The following sections provide information about the activity reported to the Chief Civil and Chief Forensic Psychiatrist as required under the *Mental Health Act 2013*.

Chief Civil Psychiatrist

i) Assessment Orders

Applications for Assessment Orders are made pursuant to section 23 of the *Mental Health Act 2013* and may be made to a medical practitioner by:

a. Another medical practitioner
b. A nurse
c. A Mental Health Officer (MHO)
d. A police officer
e. A guardian, parent or support person of the prospective patient
f. An ambulance officer
g. A person prescribed by the regulations

The applicant must be satisfied from personal knowledge of the prospective patient that the prospective patient has or might have a mental illness and that a reasonable attempt to have the patient assessed with informed consent has failed or that it would be futile or inappropriate to make such an attempt.

Assessment Orders may be made by any medical practitioner (other than the medical practitioner who applied for the Order). The medical practitioner must have examined the person in the 72 hour period immediately before or after receiving the application and be satisfied from the examination that the person needs to be assessed against the assessment criteria. The medical practitioner must also be satisfied that a reasonable attempt to have the patient assessed with informed consent has failed or that it would be futile or inappropriate to make such an attempt.

An Assessment Order may require the patient's detention in an approved hospital. It does not authorise treatment which may only be given under the authority of the Mental Health Tribunal or if authorised as Urgent Circumstances Treatment under section 55 of the Act, or if the treatment is otherwise lawful.

Table 1: Assessment Orders Made and reported to the Chief Civil Psychiatrist – 1 July 2016 to 30 June 2017 (CCP Approved Form 6).

Area	Child Female	Adult Female	Child Male	Adult Male	Total Children	Total Adults	Total Orders Made	Adult Rate / 10,000 Population
North	9	213	7	182	16	395	411	35.02
North West	10	92	4	112	14	204	218	23.21
South	5	238	6	262	11	500	511	25.00
Other[1]	0	6	0	8	0	14	14	-
Total	**24**	**549**	**17**	**564**	**41**	**1113**	**1154**	

[1] People with an interstate or overseas home address who require treatment while in Tasmania.

NOTE: The numbers in this table represent the number of assessment orders made reported to the Chief Civil Psychiatrist not the number of individuals receiving an assessment order. The Act defines a child as anyone under the age of 18.

ii) Treatment Plans

A treatment plan sets out an outline of the treatment the patient is to receive. Treatment Plans may be prepared by any medical practitioner involved in the patient's treatment or care and are required, under section 51 of the Act, for each involuntary patient. They must be made in consultation with the patient and anyone else the medical practitioner thinks fit in the circumstances. This would frequently be a guardian, parent, carer or support person of the patient. Medical practitioners preparing Treatment Plans are required to consult with all persons involved with the care of the patient wherever possible within the limits imposed by privacy and confidentiality.

Table 2: Treatment Plans Made and reported to the Chief Civil Psychiatrist – 1 July 2016 to 30 June 2017 (CCP Approved Form 7).

Area	Child Female	Adult Female	Child Male	Adult Male	Total Children	Total Adults	Total Orders Made	Adult Rate / 10,000 Population
North	2	93	2	109	4	202	206	18.05
North West	2	77	1	109	3	186	189	21.16
South	3	152	3	216	6	368	374	18.40
Other[2]	0	3	1	7	1	10	11	-
Total	**7**	**325**	**7**	**441**	**14**	**766**	**780**	

NOTE: The numbers in this table represent the number of treatment plans made reported to the Chief Civil Psychiatrist not the number of individuals receiving a treatment plan.

iii) Urgent Circumstances Treatment

Urgent circumstances treatment is treatment that is authorised by the Chief Civil Psychiatrist or a delegate as being urgently needed in the patient's best interests, under section 55 of the Act. The Urgent Circumstances Treatment provisions enable treatment that is urgently needed in the patient's best interests to be given to the patient, without informed consent or the need for Mental Health Tribunal authorisation.

Authorisation may be given on the application of any medical practitioner involved in the patient's treatment and care and following an examination by an approved medical practitioner.

Authorisation:

- Should only be applied for after reasonable attempts have been made to give the patient urgent circumstances treatment with informed consent, and these have either failed, or circumstances exist where it would be futile or inappropriate to seek to obtain the patient's informed consent to the treatment, and
- May only be given if an approved medical practitioner has concluded, from an assessment of the patient, that the urgent circumstances treatment is necessary for the patient's health or safety or the safety of other persons and that achieving the necessary treatment outcome would be compromised by waiting for the urgent circumstances treatment to be authorised by the Tribunal (or a member thereof on an interim basis) and other relevant matters.

[2] People with an interstate or overseas home address who require treatment while in Tasmania

Wherever possible, alternative, less restrictive ways of managing a patient's treatment needs should be pursued and the use of Urgent Circumstances Treatment minimised.

Urgent Circumstances treatment may be given for up to 96 hours. In most cases, it will be superseded by either a Treatment Order or an Interim Treatment Order made by the Mental Health Tribunal.

Table 3: Number of completed Urgent Circumstances Treatment notifications reported to the Chief Civil Psychiatrist - 1 July 2016 to 30 June 2017 – (CCP Approved Form 8).

Area	Child Female	Adult Female	Child Male	Adult Male	Total Children	Total Adults	Total Notifications	Adult Rate / 10,000 Population
North	13	201	7	154	20	355	375	31.72
North West	5	89	7	94	12	183	195	20.93
South	7	247	12	252	19	499	518	25.00
Other*[3]	0	7	0	7	0	14	14	-
Total	**25**	**544**	**26**	**507**	**51**	**1053**	**1104**	

NOTE: The numbers in this table represent the number of urgent circumstances treatment notifications made not the number of individuals receiving urgent treatment. The Act defines a child as anyone under the age of 18.

iv) Seclusion and Restraint

Seclusion is dealt with under section 56 of the Act while restraint is dealt with under section 57 of the Act. Seclusion or restraint may be authorised to facilitate a patient's treatment or to ensure the patient's health or safety or the safety of others. Seclusion may be understood as the deliberate confinement of an involuntary patient, alone, in a room or area that the patient cannot freely leave.

Seclusion may also be used to provide for the management, good order or security of an approved hospital while restraint, whether mechanical, physical or chemical may be used to facilitate the patient's treatment; or ensure the patient's health or safety; or ensure the safety of others; or effect a patient's transfer to another facility, whether in this State or elsewhere.

Under the Act, "mechanical restraint" is defined as a device that controls a person's freedom of movement. The Act allows an involuntary patient to be mechanically restrained only if the means of restraint employed in the specific case has been approved in advance by the Chief Civil Psychiatrist.

Under the Act, "chemical restraint" is defined as medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition. The Act allows an involuntary patient to be chemically restrained only if the restraint has been authorised as being necessary by the Chief Civil Psychiatrist.

Seclusion and restraint are extremely restrictive interventions, the application of which may cause distress for patients, support people and staff members. They are essentially interventions of last resort and may only be applied when less restrictive interventions have been tried without success or have been excluded as inappropriate or unsuitable in the circumstances.

[3] People with an interstate or overseas home address who require treatment while in Tasmania

Table 4: Number of completed Seclusion Authorisation notifications reported to the Chief Civil Psychiatrist - 1 July 2016 to 30 June 2017 – (CCP Approved Form 9).

Area	Adult Female	Adult Male	Total Notifications	Total Persons	Notification Rate / 1,000 Beds Stays
LGH	19	11	30	18	4.62
NWRH	13	13	26	15	4.31
RHH	135	60	196	75	18.08
Millbrook Rise Centre	7	3	10	5	1.04
Roy Fagan Centre	0	1	1	1	0.10
Total	174	88	263	113	6.10

NOTE: 1. The figures presented here for seclusion may differ from the National Collection of Seclusion data due to different scope of collection. 2. The total persons may not equal the sum of person by unit as individuals may be secluded in more than one unit.

The Act requires seclusion of a child to be authorised by the Chief Civil Psychiatrist or delegate. The Act defines a child as anyone under the age of 18. One notification of a child being secluded was received in 2016–17.

The median time spent in seclusion was 80 minutes.

Table 5: Number of completed Restraint Authorisation notifications reported to the Chief Civil Psychiatrist - 1 July 2016 to 30 June 2017 – (CCP Approved Form 10).

Area	Child Female	Adult Female	Child Male	Adult Male	Total Children	Total Adults	Total Persons	Notification Rate / 1,000 Beds Days
LGH	**0**	**54**	**0**	**36**	**0**	**90**	**46**	**13.85**
Mechanical	0	3	0	0	0	3	3	0.46
Physical	0	50	0	35	0	85	43	13.08
Chemical	0	1	0	1	0	2	2	0.31
NWRH	**4**	**25**	**0**	**25**	**4**	**50**	**30**	**8.30**
Mechanical	0	1	0	1	0	2	2	0.33
Physical	4	23	0	21	4	44	27	7.30
Chemical	0	1	0	3	0	4	4	0.66
RHH	**0**	**122**	**1**	**48**	**1**	**170**	**63**	**15.68**
Mechanical	0	4	1	3	1	7	7	.65
Physical	0	116	0	44	0	160	57	14.76
Chemical	0	2	0	1	0	3	3	.28
Millbrook Rise Centre	**0**	**3**	**0**	**3**	**0**	**6**	**5**	**0.62**
Mechanical	0	0	0	0	0	0	0	0
Physical	0	3	0	3	0	6	5	0.62
Chemical	0	0	0	0	0	0	0	0
Roy Fagan Centre	**0**	**2**	**0**	**1**	**0**	**3**	**3**	**0.30**
Mechanical	0	0	0	0	0	0	0	0

Area	Child Female	Adult Female	Child Male	Adult Male	Total Children	Total Adults	Total Persons	Notification Rate / 1,000 Beds Days
Physical	0	2	0	1	0	3	3	0.30
Chemical	0	0	0	0	0	0	0	0
State Total	**4**	**206**	**1**	**113**	**5**	**319**	**140**	**7.39**
Mechanical	0	8	1	4	1	12	12	0.28
Physical	4	194	0	104	4	298	130	6.91
Chemical	0	4	0	5	0	12	9	0.21

Note: Due to some individual's being restrained in more than one way the total person count at the hospital and state level may be different from the sum of the three restraint levels. Due to some individual's being restrained at more than one hospital the total person count at the state level will be different from the sum of each hospital.

The Act requires mechanical restraint, chemical restraint and physical restraint of a child to be authorised by the Chief Civil Psychiatrist or delegate. The Act defines a child as anyone under the age of 18.

The median time for a patient to be physically restrained was three minutes, with the most common reason being to facilitate the patient's treatment (43.05%), ensure the safety of others (28.81%) and ensure the patient's health or safety (20.86%).

v) Involuntary Patient Transfer Between Hospitals

Transfers of involuntary patients between hospitals are made pursuant to section 59 of the *Mental Health Act 2013*. Such transfers may be directed by the Chief Civil Psychiatrist if he or she is satisfied that the transfer is necessary for the patient's health or safety or the safety of others. No children were transferred.

Table 6: Number of Involuntary Patient Transfers between Hospitals - 1 July 2016 to 30 June 2017 (includes transfers directed by the Chief Civil Psychiatrist (CCP) and transfers directed by CCP delegates and reported to the CCP). – (CCP Approved Form 13).

Area	Originating Unit	Destination Unit	Female	Male	Total	Persons
North	LGH	NWRH	6	9	15	14
	LGH	RHH	1	3	4	4
	LGH	Roy Fagan Centre	3	1	4	3
	LGH	Millbrook Rise Centre	0	2	2	1
North West	NWRH	LGH	7	9	16	14
	NWRH	Roy Fagan Centre	3	1	4	3
	NWRH	Millbrook Rise Centre	1	1	2	2
	NWRH	RHH	2	3	5	5
South	RHH	LGH	2	1	3	3
	RHH	NWRH	2	3	5	5
	RHH	Millbrook Rise Centre	5	4	9	9
	RHH	Roy Fagan Centre	11	1	12	11
	RHH	RHH	2	0	2	2
	Millbrook Rise Centre	LGH	0	1	1	1
	Millbrook Rise Centre	RHH	2	0	2	2

Area	Originating Unit	Destination Unit	Female	Male	Total	Persons
	Roy Fagan Centre	RHH	0	1	1	1
TOTAL – State			**47**	**40**	**87**	**68**

Note: Due to some individuals being moved between a number of hospitals the total persons (state) will not equal the sum of each hospital.

vi) Failure to comply with Treatment Order

Section 47 of the Act applies if a treating medical practitioner is satisfied on reasonable grounds that a patient subject to a Treatment Order has failed to comply with the Treatment Order (despite reasonable steps being taken to obtain the patient's compliance) and such failure has seriously harmed or is likely to seriously harm the patient's health or safety or the safety of others and the harm or likely harm cannot be adequately addressed except by way of a treatment or treatment setting that is inconsistent with the Treatment Order. In this case, the treating medical practitioner may apply to the Tribunal to vary the Treatment Order, seek to have the patient taken under escort and involuntarily admitted to an approved facility, or apply to the Chief Civil Psychiatrist for authorisation to give the patient urgent circumstances treatment.

Table 7: Number of completed Failure to Comply with Treatment Order – Admission to Hospital notifications reported to the Chief Civil Psychiatrist - 1 July 2016 to 30 June 2017 – (CCP Approved Form 22).

Area	Child Female	Adult Female	Child Male	Adult Male	Total Children	Total Adults	Total Persons
LGH	0	4	0	7	0	11	9
NWRH	0	3	0	3	0	6	6
RHH	0	4	0	9	0	13	11
Total	**0**	**11**	**0**	**19**	**0**	**30**	**26**

Chief Forensic Psychiatrist

i) Urgent Circumstances Treatment

Urgent circumstances treatment is treatment that is authorised by the Chief Forensic Psychiatrist or a delegate as being urgently needed in the patient's best interests, under section 87 of the Act. The Urgent Circumstances Treatment provisions enable treatment that is urgently needed in the patient's best interests to be given to the patient, without informed consent or the need for Mental Health Tribunal authorisation.

Authorisation may be given on the application of any medical practitioner involved in the patient's treatment and care and following an examination by an approved medical practitioner.

Authorisation:

- Should only be applied for after reasonable attempts have been made to give the patient urgent circumstances treatment with informed consent, and these have either failed, or circumstances exist where it would be futile or inappropriate to seek to obtain the patient's informed consent to the treatment, and

- May only be given if an approved medical practitioner has concluded, from an assessment of the patient, that the urgent circumstances treatment is necessary for the patient's health or safety or the safety of other persons and that achieving the necessary treatment outcome would be compromised by waiting for the urgent circumstances treatment to be authorised by the Tribunal (or a member thereof on an interim basis) and other relevant matters.

Wherever possible, alternative, less restrictive ways of managing a patient's treatment needs should be pursued and the use of Urgent Circumstances Treatment minimised.

Urgent circumstances treatment may be given for up to 96 hours. In most cases, it will be superseded by treatment that is authorised by the Mental Health Tribunal under sections 88 or 91 of the Act.

Table 8: Number of completed Urgent Circumstances Treatment notifications reported to the Chief Forensic Psychiatrist - 1 July 2016 to 30 June 2017 – (CFP Approved Form 8F).

	Child Female	Adult Female	Child Male	Adult Male	Total Children	Total Adults	Total Persons
	0	0	0	4	0	4	4
Total	**0**	**0**	**0**	**4**	**0**	**4**	**4**

ii) Seclusion and Restraint

Seclusion for forensic patients is dealt with under section 94 of the Act while restraint for forensic patients is dealt with under section 95 of the Act.

Seclusion may be understood as the deliberate confinement of an involuntary patient, alone, in a room or area that the patient cannot freely leave.

Seclusion or mechanical or physical restraint may be authorised to facilitate a patient's treatment or general health care, to ensure the patient's health or safety or the safety of others, to prevent the patient from destroying or damaging property, to prevent the patient's escape from lawful custody, to provide for the management, good order or security of the Secure Mental Health Unit (SMHU), to facilitate the patient's lawful transfer to or from another facility or for a reason sanctioned by CFP standing orders.

Chemical restraint may only be authorised to facilitate a patient's treatment, to ensure the patient's health or safety or the safety of others, or to facilitate the patient's lawful transfer to or from another facility.

Under the Act, "mechanical restraint" is defined as a device that controls a person's freedom of movement. The Act allows an involuntary patient to be mechanically restrained only if the means of restraint employed in the specific case has been approved in advance by the Chief Forensic Psychiatrist.

Under the Act, "chemical restraint" is defined as medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition. The Act allows an involuntary patient to be chemically restrained only if the restraint has been authorised as being necessary by the Chief Forensic Psychiatrist.

Seclusion and restraint are extremely restrictive interventions, the application of which may cause distress for patients, support people and staff members. They are essentially interventions of last resort and may only be applied when less restrictive interventions have been tried without success or have been excluded as inappropriate or unsuitable in the circumstances.

Table 9: Number of completed Seclusion Authorisation notifications reported to the Chief Forensic Psychiatrist - 1 July 2016 to 30 June 2017 – (CFP Approved Form 9F).

	Child Female	Adult Female	Child Male	Adult Male	Total Children	Total Adults	Total Persons
	0	4	0	20	0	24	9
Total	**0**	**4**	**0**	**20**	**0**	**24**	**9**

Table 10: Number of completed Restraint Authorisation Notifications reported to the Chief Forensic Psychiatrist - 1 July 2016 to 30 June 2017 – (CFP Approved Form 10F).

	Child Female	Adult Female	Child Male	Adult Male	Total Children	Total Adults	Total Persons
Mechanical	0	0	0	3	0	3	2
Physical	0	0	0	11	0	11	8
Chemical	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**14**	**0**	**14**	**9**

Note: Due to some individual's being restrained in more than one way the total person count will be different from the sum of the three restraint levels

iii) Leave Of Absence

Under sections 81 – 84 of the Act, the Chief Forensic Psychiatrist or a delegate may grant a forensic patient who is not subject to a restriction order leave of absence in Tasmania. Such leave may be granted for a particular purpose, or for a particular period, or both. Leave is granted subject to such conditions as the Chief Forensic Psychiatrist considers necessary and desirable for the patient's health or safety or for the safety of others. This may extend to a requirement that the patient be under escort during the leave or any portion of the leave.

Table 11: Number of completed Leave of Absence notifications reported to the Chief Forensic Psychiatrist - 1 July 2016 to 30 June 2017 - (CFP Approved Form 12F).

	Child Female	Adult Female	Child Male	Adult Male	Total Children	Total Adults	Total Persons
	0	0	0	9	0	9	2
Total	**0**	**0**	**0**	**9**	**0**	**9**	**2**

iv) Forensic Patient Transfer to Hospital

Transfer of forensic patients to a secure institution, an approved hospital, a health service within the meaning of the *Health Complaints Act 1995*, or premises where such a health service is provided, may be made pursuant to section 73 of the *Mental Health Act 2013*. Transfer is directed by the Chief

Forensic Psychiatrist or delegate and would generally be for the purposes of receiving specialised care in that facility.

Table 12: Number of Forensic Patient Transfers to Hospital - 1 July 2016 to 30 June 2017 (includes transfers directed by the Chief Forensic Psychiatrist (CFP) and transfers directed by CFP delegates and reported to the CFP). – (CFP Approved Form 17F).

	Child Female	Adult Female	Child Male	Adult Male	Total Children	Total Adults	Total Persons
	0	1	0	81	0	82	22
Total	**0**	**1**	**0**	**81**	**0**	**82**	**22**

v) Cancellation or Suspension of Visit

Under section 98(4) of the Act, the Chief Forensic Psychiatrist may cancel or suspend for a time any individual's privileged visitor, privileged caller, or privileged correspondent status if he or she is satisfied on reasonable grounds that the individual has engaged in behaviour that is incompatible with the management, good order or security of a secure mental health unit.

Table 13: Number of completed Cancellation or Suspension of Visits by the Chief Forensic Psychiatrist - 1 July 2016 to 30 June 2017 – (CFP Approved Form 18F).

NIL cancellations or suspensions.

vi) Involuntary Patient Transfer to Secure Mental Health Unit

Under section 63 of the Act, an involuntary patient may be admitted to a secure mental health unit if the admission is authorised by the Chief Forensic Psychiatrist or delegate upon the formal request of the Chief Civil Psychiatrist or delegate.

Authorisation may be given only if, amongst other criteria, the patient is being detained in an approved hospital, is not a prisoner or youth detainee, and if the Chief Forensic Psychiatrist is satisfied that the patient is, by reason of mental illness, a danger to himself or herself or to others and, in the circumstances, the secure mental health unit is the only appropriate place where the patient can be safely detained.

A child (defined in the Act as a person under 18 years) may only be admitted to a secure mental health unit if the Chief Forensic Psychiatrist is, in addition to the matters outlined above, also satisfied that the patient can be detained separately from adults, and that the probable benefits of accommodating the patient in a secure mental health unit outweigh the probable risks.

Table 14: Number of completed Involuntary Patient Transfers to Secure Mental Health Unit authorised by the Chief Forensic Psychiatrist or delegate under the Mental Health Act 2013 from 1 July 2016 to 30 June 2017 – (CFP Approved Form 19F).

	Child Female	Adult Female	Child Male	Adult Male	Total Children	Total Adults	Total Persons
	0	3	0	3	0	3	5
Total	**0**	**3**	**0**	**3**	**0**	**3**	**5**

In accordance with section 63 of the Act, involuntary patients are only transferred to a secure mental health unit in situations where the danger that the patient poses to self or others by reason

of mental illness is or has become so serious as to make the patient's continued detention in an approved hospital untenable.

vii) Request To Return To Prison

Under section 70 of the *Mental Health Act 2013*, a forensic patient who is a prisoner or youth detainee and whose removal to the SMHU was directed at the patient's own request may request the Chief Forensic Psychiatrist to return him/her to the custody of the relevant authority at any time.

The Chief Forensic Psychiatrist is to have the patient examined by an approved medical practitioner before either agreeing to the request or refusing the request. In considering the request, the Chief Forensic Psychiatrist is to have regard to the results of the examination and whether the reasons for the patient's admission are still valid, as well as such other matters as the Chief Forensic Psychiatrist considers relevant.

Table 15: Number of completed Requests to Return to Prison received by the Chief Forensic Psychiatrist under the Mental Health Act 2013 from 1 July 2016 to 30 June 2017 – (CFP Approved Form 20F).

NIL requests to return to prison.

5. Other Roles and Functions

Approved Medical Practitioners and Nurses

Pursuant to section 138 of the *Mental Health Act 2013*, a Chief Psychiatrist, by instrument in writing, may approve individual people (or all members of a class of persons) as Medical Practitioners or as Nurses for provisions of the Act or any other Act where the Chief Psychiatrist may have responsibilities. To be approved as a medical practitioner a person must be a psychiatrist or a medical practitioner who is otherwise qualified or experienced in the diagnosis or treatment of mental illness. To be approved as a nurse a person must be a registered nurse who is qualified or experienced in the treatment or care of people with mental illness.

For the period 1 July 2016 to 30 June 2017 there were 68 approvals, under section 138 of the Act, of individuals as Medical Practitioners for all of the provisions of the Act within the Chief Civil Psychiatrist and Chief Forensic Psychiatrist's jurisdictions and nil revocations.

Mental Health Officers

Pursuant to section 139 of the *Mental Health Act 2013*, a Chief Psychiatrist, by an instrument in writing, may approve individuals (or all members of a class of persons) as Mental Health Officers (MHOs) for provisions of the Act or any other Act where the Chief Psychiatrist may have responsibilities. To be approved, a person must have skills, qualifications or experience relevant to the responsibilities of MHOs under the relevant statutory provisions.

For the period 1 July 2016 to 30 June 2017 there were 41 approvals, under section 139 of the Act, of individuals as Mental Health Officers for all of the provisions of the Act within the Chief Civil Psychiatrist and Chief Forensic Psychiatrist's jurisdictions and no revocations.

There were 34 approvals under section 139 of the Act, of all members of a class of persons (certain ambulance officers) as Mental Health Officers for provisions of the Act within the Chief Civil Psychiatrist and Chief Forensic Psychiatrist's jurisdictions since commencement of the Act and one revocation.

Standing Orders and Clinical Guidelines

Pursuant to sections 151 and 152 of the *Mental Health Act 2013*, a Chief Psychiatrist may issue clinical guidelines and standing orders to help controlling authorities, medical practitioners, nurses or others regarding the exercise of their responsibilities regarding any clinical or non-clinical procedure or matter under provisions of the Act or any other Act where the Chief Psychiatrist may have jurisdiction or responsibilities.

A full list of Standing Orders and Clinical Guidelines introduced by the Chief Civil Psychiatrist and the Chief Forensic Psychiatrist since the commencement of the Act can be found at Appendix 1.

6. Functions Specific to the Chief Forensic Psychiatrist

The Chief Forensic Psychiatrist has a number of legislated functions under Acts other than the *Mental Health Act 2013*, including the *Criminal Justice (Mental Impairment) Act 1999* the *Sentencing Act 1997*, the *Criminal Code Act 1924*, the *Corrections Act 1997* and the *Youth Justice Act 1997*.

A full list of these functions can be found at Appendix 2.

7. Patient and Service Reporting

Mental Health Facilities and Services

Mental Health Services (MHS) provides specialist clinical mental health services across the state targeted at the estimated three per cent of the Tasmanian community experiencing a severe mental illness. These services are primarily focussed on secondary and tertiary level care for people with serious mental disorders and are provided through the Tasmanian Health Service.

Community mental health services

Community mental health services are delivered over three service streams comprising:

- Child and Adolescent Mental Health Services (CAMHS)
- Adult Community Mental Health Services (ACMHS)
- Older Persons Mental Health Services (OPMHS).

Crisis Assessment Treatment and Triage (CATT) services are delivered through community mental health services, providing a mental health crisis response including assessment and triage.

The Mental Health Services Helpline is a 24 hour, seven days a week statewide telephone triage service.

Inpatient and Extended Treatment Mental Health Services

Acute care inpatient units are located at the three public hospitals and offer 24 hour care and treatment. These facilities include Northside Mental Health Clinic (20 beds located at the Launceston General Hospital), Spencer Clinic (19 beds located at the North West Regional Hospital) and the Department of Psychological Medicine (32 bed located at the Royal Hobart Hospital). The inpatient unit at the RHH was moved in November 2016 from the 33 bed unit in B Block to a 32 bed unit in the new temporary F Block to allow for building works on the RHH campus.

Specialist extended treatment facilities are located in the south and provide statewide services including Millbrook Rise Centre (27 beds), Roy Fagan Centre (32 beds), Mistral Place (10 beds) and Tolosa Street Units (12 beds).

Forensic Mental Health Services (FMHS)

Provide community and inpatient mental health care for people experiencing a mental health disorder, who are involved with or at risk of becoming involved with the criminal justice system.

Services are delivered across three streams:

Inpatient Forensic Mental Health Services

These services are provided at Tasmania's secure mental health unit, the Wilfred Lopes Centre (WLC), which is located near but separate from the Risdon Prison complex. WLC commenced operation in February 2006 and is a purpose built dedicated forensic facility, owned by the Department of Health and Human Services (DHHS), and managed on a statewide basis by the Tasmanian Health Service, and is Tasmania's first secure mental health unit.

Patients admitted to WLC generally include those found not guilty by reason of insanity or unfit to plead, people with mental illnesses appearing in or remanded from the courts or sent by the courts for assessment, and prisoners with a mental illness or mental health issue that requires specialist mental health inpatient treatment.

Community Forensic Mental Health Services

Includes services provided to the Tasmanian Prison Service and the WLC and community case management across the state within the general community.

Court Liaison Services

Assist in the assessment and identification of people before the judiciary who may not be fit to plead and/or require diversion into a mental health setting through the Mental Health Diversion List (MHDL). FMHS works in partnership with the Department of Justice to facilitate the MHDL initiative.

Approved Facilities and Secure Mental Health Units

The Chief Civil Psychiatrist has a general and overall responsibility under and to the Minister, for ensuring that the objects of the Act are met regarding the running of approved facilities other than secure mental health units. The Chief Forensic Psychiatrist has a general and overall responsibility under and to the Minister, for ensuring that the objects of the Act are in relation to the running of secure mental health units.

The Chief Civil Psychiatrist also has a general overall responsibility, under and to the Minister to ensure that the objects of the Act are met in relation to patients other than forensic patients or those who are subject to supervision orders, with the Chief Forensic Psychiatrist being similarly responsible for forensic patients and those subject to supervision orders.

8. Inpatient Services for Children and Youth

The Chief Psychiatrist has a major role in oversighting the treatment of children under the *Mental Health Act 2013*. Tasmania does not have a dedicated Child and Adolescent Mental Health inpatient unit. In the light of this mental health care to children and young people under the age of 18 is provided in the community wherever possible. Where the clinical situation is such that inpatient care is seen as the most appropriate form of care, the preferred option is to provide mental health care and support on the paediatric wards. There are, however situations in which the most appropriate form of treatment for young people is for them to be nursed one to one in an adult mental health unit until it becomes clinically appropriate to treat the young person either on a paediatric ward or back in the community.

Table 16: Children and Youth Separations from Mental Health Inpatient Wards from 1 July 2016 to 30 June 2017

	Northside	Spencer	DOP	DPM	PICU
Female					
<18	2	4	1	0	0
Male					
<18	7	5	2	3	1
Total <18	9	9	3	3	1
Total Separations	634	379	577	402	52
% of Separations <18	1.42%	2.37%	0.52%	1.92%	1.22%
11 years				1	
14 years	1				
15 years	3	1			
16 years		1			
17 years	5	7	3	2	1

The small numbers of children and youths admitted to a mental health inpatient ward reflects the efforts of clinicians to ensure that this group of patients are treated in the least restrictive environment possible.

Admission to a mental health ward for this group of young people is only undertaken in situations where the behaviour of the young person is such that there is a high risk of harm to themselves or others if admitted to a non-mental health inpatient ward.

Ongoing assessment and treatment of the young person is continuous, with regular evaluation of the need for detention of the young person in the mental health unit.

Wherever possible, and where clinically appropriate, children are admitted to a paediatric unit rather than a designated mental health unit. In such a unit, highly skilled staff are able to ensure a high level of age-appropriate care and treatment.

Table 17: Children and Youth with a Mental Health related DRG Discharged from non-Mental Health Inpatient Wards from 1 July 2016 to 30 June 2017[4]

Age	LGH Paediatric Ward	NWRH Paediatric Ward	RHH Paediatric Ward	RHH Paediatric Ambulatory (Out-Patient Clinics)	Emergency Departments	Other	TOTAL
1	1			1			2
2			1	1			2
3				1			1
4	2		1			1	4
5	2		2	1			5
6			1	3			4
7	2			2			4
8	1		1	1			3
9							
10	4	1	2				7
11	1	1	2	1		1	6
12	3	1	5	1	1		11
13	3	3	10	2	2		20
14	18	1	6		5		30
15	9	4	15		6		34
16	12	3	21	1	4	1	42
17	15		22		3	2	42
TOTAL	**73**	**14**	**89**	**15**	**21**	**5**	**217**

9. Key Initiatives and Areas of Interest to the Chief Psychiatrist

Seclusion and Restraint

During 2015-16 the Chief Psychiatrist supported the establishment of a Statewide Restrictive Interventions Review Panel with the aim of reviewing all incidents of restrictive practices. This panel meets on a quarterly basis and receives reports from all local areas in which seclusion or restraint may take place. A Seclusion/Restraint record is completed for each episode of restrictive practice which enables a close examination of factors leading to the initiation of the practice, safety measures taken and medical/nursing reviews. It is considered that such reviews will identify both structural and case-specific problems and will enable discussion and implementation of suitable remedies aimed at reducing these practices.

Table 18: Seclusion Rate by inpatient unit for the period 2011 – 12 to 2016-17

Unit	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Northside	6.96	5.18	16.01	9.2	14.3	4.3
Spencer	8.67	8.43	5.87	5.7	4.8	5.6
Department of Psychiatry	17.17	37.12	23.60	15.3	17.8	17.9
Wilfred Lopes Centre	6.80	2.82	4.86	5.8	10.0	7.0

[4] Patients under 18 years of age with a DRG in the range U40Z to U68Z

Unit	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
TOTAL	11.87	19.74	15.20	10.1	13.1	10.2

Strategic Service Development

There are a number of initiatives which, while not directly related to the operation of the Act, are system level and whole of service issues, warrant the consideration of the Chief Psychiatrist as the senior mental health clinician in Tasmania.

Rethink Mental Health

Rethink Mental Health, Better Mental Health and Wellbeing – A Long-Term Plan for Mental Health in Tasmania 2015-2025 was launched in October 2015 and outlines a commitment to develop an integrated Tasmanian Mental Health System that provides support in the right place, at the right time and with clear signposts about where and how to get help.

The Plan establishes a 10-year vision that brings together action to strengthen mental health promotion, prevention and early intervention, action to improve care and support for people with mental illness, their families and carers and sets a path for integrating Tasmania's mental health system. It includes short, medium and long-term actions to achieve this vision. The Plan identifies 10 reform directions:

- Empowering Tasmanians to maximise their mental health and well-being.
- A greater emphasis on promotion of positive mental health, prevention of mental health problems and early intervention.
- Reducing stigma.
- An integrated Tasmanian mental health system.
- Shifting the focus from hospital-based care to support in the community.
- Getting in early and improving timely access to support (early in life and early in illness).
- Responding to the needs of specific population groups.
- Improving quality and safety.
- Supporting and developing our workforce.
- Monitoring and evaluating our action to improve mental health and well-being.

Implementation of the Plan is being led by the Chief Psychiatrist and the Mental Health, Alcohol and Drug Directorate. The Chief Psychiatrist Chairs the Rethink Mental Health Plan Implementation Steering Committee established to oversee implementation of the Plan.

Suicide Prevention

In September 2017, the Australian Bureau of Statistics (ABS) reported that the five-year age-standardised suicide rate for Tasmania (2012-2016) was 14.8 per 100 000. This figure is above the national suicide rate of 11.8 per 100 000 and is second highest of all jurisdictions, behind only the Northern Territory at 19. (The 2016 data is preliminary data that is subject to the ABS review process). Suicide prevention is a public health issue for the whole of government and the community and merits a comprehensive approach. This approach underpins the Tasmanian Government's new suicide prevention policy direction that was launched in 2016.

Tasmania's new suicide prevention policy framework is outlined in a suite of three documents.

The ***Tasmanian Suicide Prevention Strategy (2016-2020)*** builds on previous directions which emphasised the importance of working with ready communities to raise awareness of suicide risk and protective factors to respond to suicide risk. The Strategy outlines action to be taken in five priority areas:

1. Create a responsive, co-ordinated health service system for people experiencing suicidal thoughts and behaviours and build and promote referral pathways to services and programs so people know how and where to get support.
2. Empower and support young people, families and communities to respond to suicidal behaviours and the impact of suicidal behaviours.
3. Implement public health approaches to reduce suicidal behaviour and increase community literacy about suicide and suicide prevention.
4. Ensure effective implementation, monitoring and evaluation of the Strategy.
5. Train and support health workers and other gatekeepers to provide effective and compassionate care and support for people experiencing suicidal thoughts and behaviours – *Suicide Prevention Workforce Development and Training Plan for Tasmania (2016-2020).*

The ***Youth Suicide Prevention Plan for Tasmania (2016-2020)*** takes an evidence-based approach to taking action to reduce youth suicide, suicidal behaviour and the impact upon young people in Tasmania. This Plan identifies five priority areas:

1. Start early by focusing on the resilience, mental health and well-being of children, parents and families.
2. Empower young people, families and wider community networks to talk about suicide and respond to young people at risk of suicide.
3. Build the capacity of schools, and other educational settings to support young people who may be at risk of suicide or impacted by suicide.
4. Develop the capacity of the service system to support young people experiencing suicidal thoughts and behaviours.
5. Respond in a timely and effective way to the suicide of a young person to minimise the impact on other young people in Tasmania.

The goal of the **Suicide Prevention Workforce Development and Training Plan for Tasmania (2016-2020)** is to support priority workforces to provide effective and compassionate care and support to people experiencing suicidal thoughts and behaviours. This Plan prioritises the following groups:

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

The Chief Psychiatrist is working with the Mental Health and Alcohol and Drug Directorate (the Directorate) in leading state government funded suicide prevention policy, planning, purchasing and monitoring in Tasmania; and is Chair of the Tasmanian Suicide Prevention Committee, which provides high level strategic advice and leadership in suicide prevention activities in Tasmania. The Chief Psychiatrist also has an important role in providing advice regarding the evidence for suicide prevention strategies and in the implementation of the Tasmanian Government's suicide prevention policy framework.

Safety and Quality

Every Tasmanian with mental health needs should be able to access high quality, safe mental health services that uphold the rights and responsibilities of the consumer, their carers and their family.

The National Standards for Mental Health Services (the Standards) were first introduced in 1996 to assist in the development and implementation of appropriate practices and guide continuous quality improvement in mental health services. The Standards have been regarded as a positive in the mental health service sector and have been integral in shaping how services responded to the needs and expectations of consumers and carers.

The Standards were revised in 2010 with Standard 2: Safety, stating: The activities and environment of the MHS are safe for consumers, carers, families, visitors, staff and its community.

Quality improvement and innovation are action areas under the Fourth National Mental Health Plan 2009 – 2014. The recent National Mental Health Report 2013 outlined progress against a range of actions including the development of a national mental health research strategy to drive collaboration and inform the research agenda.

Developing and maintaining a safe and high quality mental health care system is a core function of all mental health care staff. It requires strong leadership, teamwork and a shared commitment to fostering a culture of service improvement to achieve the best outcomes for mental health consumers. Safeguarding this system requires a commitment to high standards of care and ongoing accountability; to new and emerging evidence and innovation in care; robust clinical governance; and the integration of the views of mental health consumers, their family and carers through strengthening consumer and carer participation. It also requires a commitment to safety and quality in non-clinical settings and within the broader community.

The Chief Psychiatrist represents Tasmania as a member of the Safety and Quality Partnership Standing Committee (SQPSC), a sub-group of the Mental Health Standing Committee (MHSC). The SQPSC provides expert technical advice and recommendations on the development of national policy and strategic directions for safety and quality in mental health taking into consideration the National Mental Health Strategy, , the recently released Fifth National Mental Health Plan and mainstream health initiatives. The SQPSC may respond, through the provision of advice to the MHSC, on emerging issues of concern and related safety and quality issues. Issues of concern to the SQPSC include:

- The implementation of National Standards
- Suicide Prevention – here, the SQPC is focusing on improving the clinical approach through benchmarking and standards.
- Physical Health Care – improving the outcomes for people with serious mental illness and psychological wellbeing of people with chronic illness.
- Adverse Medication Events – examining medication safety and focusing on reducing adverse events.
- Restrictive Practice – reducing restrictive/coercive practices and maintaining a focus on reducing seclusion and restraint in mental health facilities.
- Trauma Informed Care – this is a strategic direction for policy and practice reform across all mental health services and aims at recognition and acknowledgement of trauma and its prevalence, alongside awareness and sensitivity to its dynamics.

- Peer Workforce – consumer and carer peer workers are an integral part of the mental health workforce with the level of consumer and carer workers employed within mental health services being a key indicator for a recovery oriented system.
- National Disability Insurance Scheme Quality and Safeguarding Framework – primary areas of importance to mental health involve supported decision making, National Standards and restrictive practices.

Participation in the work of the SQPSC enables the Chief Psychiatrist to report on the progress of these initiatives from the Tasmanian perspective and to ensure, through the Mental Health, Alcohol and Drug Directorate, that they become a focus of attention for the delivery of mental health services within Tasmania.

Appendix 1: A List of Standing Orders and Clinical Guidelines Introduced by the Chief Civil Psychiatrist (CCP) and Chief Forensic Psychiatrist (CFP) since the introduction of the *Mental Health Act 2013*

Since the introduction of the Act, the Chief Civil Psychiatrist (CCP) has issued the following Standing Orders:

- CCP Standing Order 8 – Urgent Circumstances Treatment
- CCP Standing Order 9 – Seclusion
- CCP Standing Order 10 – Chemical Restraint
- CCP Standing Order 10A – Mechanical and Physical Restraint
- CCP Standing Order 19 – Involuntary Patient Admission to Secure Mental Health Unit

Since the introduction of the Act, the Chief Forensic Psychiatrist (CFP) has issued the following Standing Orders:

- CFP Standing Order 8 - Urgent Circumstances Treatment
- CFP Standing Order 9 – Seclusion
- CFP Standing Order 10 – Chemical Restraint
- CFP Standing Order 10A – Mechanical and Physical Restraint
- CFP Standing Order 15 – Visitor Identification
- CFP Standing Order 16 – Entry Screen and Search
- CFP Standing Order 17 – Unauthorised Items
- CFP Standing Order 19 – Involuntary Patient Admission to Secure Mental Health Unit
- CFP Standing Order 21 – Use of Force

Since the introduction of the Act, the Chief Civil Psychiatrist has issued the following Clinical Guidelines:

- CCP Clinical Guideline 1 – Meaning of Mental Illness
- CCP Clinical Guideline 2 – Capacity
- CCP Clinical Guideline 3 – Representative and Support Persons
- CCP Clinical Guideline 8 – Urgent Circumstances Treatment
- CCP Clinical Guideline 9 – Seclusion
- CCP Clinical Guideline 10 – Chemical Restraint
- CCP Clinical Guideline 10A – Mechanical and Physical Restraint

Since the introduction of the Act, the Chief Forensic Psychiatrist has issued the following Clinical Guidelines:

- CFP Clinical Guideline 2 – Capacity

- CFP Clinical Guideline 3 – Representative and Support Persons
- CFP Clinical Guideline 8 – Urgent Circumstances Treatment
- CFP Clinical Guideline 9 – Seclusion
- CFP Clinical Guideline 10 – Chemical Restraint
- CFP Clinical Guideline 10A – Mechanical and Physical Restraint

Appendix 2: A Full List of Functions Undertaken By the Chief Forensic Psychiatrist (CFP) under Acts Other Than the *Mental Health Act 2013*

Under the *Criminal Justice (Mental Impairment) Act 1999*, the Chief Forensic Psychiatrist's functions include:

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

The Chief Forensic Psychiatrist's functions under the *Sentencing Act 1997* are to provide advice to the Court under section 72 and report to the Court under section 75.

The Chief Forensic Psychiatrist's functions under the *Criminal Code Act 1924* are to report to the Court under section 348 and to apply to the Court for revocation of a restriction order under section 348.

The Chief Forensic Psychiatrist's functions under the *Corrections Act 1997* are to have input to a decision to admit a prisoner to the SMHU under section 36A, to require the Director, Corrective Services, to remove a prisoner or detainee who has been admitted to the SMHU from the SMHU under section 36A, and to supply to Parole Board with a report under section 74.

The Chief Forensic Psychiatrist's functions under the *Youth Justice Act 1997* include:

- Reporting to the Court under section 105
- Reporting to the Court under section 134A
- Having input to the decision to admit a youth detainee to the SMHU under section 134A
- Requiring the Secretary, Youth Justice to remove a youth detainee from the SMHU under section 134A