ANNUAL REPORT

2021 - 2022

CHIEF CIVIL PSYCHIATRIST

CHIEF FORENSIC PSYCHIATRIST

Office of the Chief Psychiatrist
Department of Health

Tasmanian Government

For more information

Office of the Chief Psychiatrist
Department of Health
GPO Box 125
HOBART TAS 7001
Tel: 03 6166 0778
Email: chief.psychiatrist@health.tas.gov.au

CONTENTS

CHIEF PSYCHIATRIST'S MESSAGE

I am pleased to present this Annual Report of the Chief Civil Psychiatrist and Chief Forensic Psychiatrist in accordance with section 150 of the *Mental Health Act 2013* (Tas) (the Act) for the period 1 July 2021 – 30 June 2022.

This report is my first as the Acting Chief Civil Psychiatrist and Chief Forensic Psychiatrist for Tasmania and provides an outline of the Chief Psychiatrists' activities during the 2021-22 Financial Year. It reports on the statutory functions of the Chief Psychiatrists under the Act and makes observations and presents data about these associated functions.

This year has once again been very busy with a range of activities and reforms that we have continued to implement. The Review of the Act's Operation is well into stage one of the implementation, and I have been project managing this with support from a dedicated project officer who will continue to progress this work over the next 12 months as we move into stage two of the implementation phase. The implementation phase is two-staged approach broken into shorter and longer-term actions, with tranche one due for completion by the end of 2022 and tranche two by the end of 2023. The Office of the Chief Psychiatrist continues to work closely with Statewide Mental Health Services, the Tasmanian Civil and Administration Tribunal-Protective Division-Mental Health Stream (TASCAT), Legal Aid, Official Visitors, and lived experience representatives throughout the implementation. The full implementation of the review outcomes will see the Chief Civil Psychiatrist and Chief Forensic Psychiatrist separate titles merge into the one new title of Chief Psychiatrist consistent with other states. More information about the review implementation can be found on page 28. I would like to thank all our key stakeholders for their time and contribution to this important project.

The Office of the Chief Psychiatrist (OCP) now has a comprehensive work plan in place to better articulate the roles and functions of the office, to identify the advisory and statutory functions, and to link our key priorities and intersecting advisory projects with the Mental Health, Alcohol and Drug Directorate. The OCP work plan is a live document that is regularly updated and provides a structured approach for escalating outstanding actions or barriers, risks and issues impeding progress of our work to the Deputy Secretary, Community, Mental Health, and Wellbeing.

In November 2021the new Tasmanian Civil and Administrative Tribunal (TASCAT) Protective Division- Mental Health Stream was established under the new *Tasmanian Civil and Administrative Tribunal Act 2020* replacing the former Mental Health Tribunal as the independent body to authorise and review the treatment of people with mental illness and forensic patients, who, due to their mental illness, are not at the time able to make decisions associated with their treatment and care. I would like to congratulate TASCAT on a smooth transition to their new structure and governance, and from my perspective, the impact on patients and services during the transition has been limited. I will continue to work closely with the Deputy President, TASCAT Mental Health Stream to identify any issues around compliance or application of the Mental Health Act and important oversight of patients' rights.

A key focus of the Office of the Chief Psychiatrist and the Mental Health, Alcohol and Drug Directorate over the last quarter has been to lead the development of an overarching Statewide Mental Health Clinical Services Plan for Tasmania to complement existing planning across the organisation. This work has been supported by an external consultant who has been trained in the National Mental Health Service Planning Framework (NMHSPF).

The Plan will be underpinned by robust, evidence-based modelling and reflect contemporary best practice and changes in epidemiology. The Plan is a key application of the NMHSPF which is Priority Area 1-*Achieving integrated regional planning and service delivery* of the Fifth National Mental Health and Suicide Prevention Plan (The Fifth Plan).

The Clinical Services Plan will comprise the following elements specific to mental health:

- a Role Delineation Framework (RDF)
- a Clinical Service Profile for each part of Statewide Mental Health Services
- a Clinical Service Capability Framework (CSCF)
- an enumeration of the clinical services needed consistent with the RDF and based on the latest version of the National Mental Health Service Planning Framework (NMHSPF).

A technical document that supports the basis of the planning which will be delivered to the Department of Health towards the end of 2022. The Plan will incorporate acute and non-acute services including Child and Adolescent Mental Health, Forensic Mental Health, Older Persons Mental Health, Adult Mental Health, and Inpatient Mental Health Services. The Plan will also support the modelling to resource the new St Johns Park development and the Peacock Centre redevelopment.

Throughout July and August this year Dr Aaron Groves chaired public consultations around the state including rural and remote areas with the Mental Health, Alcohol and Drug Directorate as part of the development of the next Tasmanian Suicide Prevention Strategy. The development of a new Strategy is a key action under *Rethink Mental Health 2020.* I believe it was invaluable to hear from people who have direct experience with suicide to better understand the current issues to advise the Tasmanian Government about the direction of suicide prevention in Tasmania and the priority areas for targeting resources over the next five years to better meet the needs of our community. The Mental Health, Alcohol and Drug Directorate also surveyed a number of community organisations including veteran support and counselling services and peak bodies and it is pleasing to see the Tasmanian and Commonwealth Governments commitment to invest funding to improve veteran mental health and wellbeing services and to expand service delivery into rural and remote areas.

It is exciting to see the extensive reform activity continuing in southern Tasmania led by the Tasmanian Mental Health Reform Program with new services extending to the North and North West in the future, including the Mental Health Co-Response Service Northwest (PACER). This Government continues to support the much-needed investment for new services and system reform to respond to the increasing demand on public and community mental health services in Tasmania supporting the initial recommendations from the Mental Health Integration Taskforce Report released in April 2019. The redeveloped Peacock Centre is on track to be operational from mid-March 2023 compromising of a 12-bed Community Acute Treatment Unit, a Safe Haven, an Integration Hub, and a Recovery College Classroom. The new development at St Johns Park is scheduled to be operational in the first quarter of 2024 and will deliver a second 15-bed Community Acute Treatment Unit, another Safe Haven, Integration Hub and Recovery College, and a residential Tasmanian Eating Disorders Service-a first for Tasmania.

Work continues to progress long-standing issues associated with people on civil mental health orders who move jurisdiction, or request to move between jurisdictions with the desired outcome being that people subject to these orders will be automatically recognised in all states and territories should they relocate, without needing to undergo a new mental health order application process. I will be the Tasmanian representative on the National Mutual Recognition Interjurisdiction Project Steering Committee. A daft Mental Health Orders (Mutual Recognition) Model Provisions has been provided to the National Mutual Recognition Steering Committee for consideration, and I will be able to provide more information in the next report.

I would like to also take this opportunity once again to thank the Legal Orders Coordinators around the State who provide the Tasmanian Health Service with support every day to ensure the Act is complied with and the necessary documentation is provided to the Office of the Chief Psychiatrist and TASCAT. The Legal Orders Coordinators continue to be proactive in contacting the Office of the Chief Psychiatrist if they are unsure about certain aspects of the Acts application, or if there are matters regarding non-compliance with the Act that require the attention of our office. The Legal Orders Coordinators have also been instrumental in the work being undertaken to support the Act review implementation, particularly their engagement on the Mental Health Act Reform Implementation Forms and Documents Working Group which has been invaluable given their operational experience.

I also want to acknowledge that the work of the Chief Psychiatrist has been assisted by close working relationships with Statewide Mental Health Services, TASCAT, Mental Health Official Visitors Scheme, the Public Guardian, the Office of the Health Complaints Commission, and the Tasmanian Ombudsman (and staff in their respective offices). Regular liaison with each of these authorities has enabled matters of shared interest to be collectively explored and, in many cases, resolved.

I would also like to thank the clinicians, service leaders, and people with lived experience who continue to share their expertise and experience with us and provide essential input and insight as new initiatives, reform and policy is implemented locally and nationally. I would also like to extend my thanks to the Office of the Chief Psychiatrist Lived Experience Advisory Group for their contribution through this reporting period.

I would also like to thank Dr Ed Elcock for his contribution to the Office of the Chief Psychiatrist during his psychiatrist registrar rotation placement with us. Although the time went quickly, Dr Elcock provided us with valuable insight into the operational issues in our services which we have been able to factor this into the Act review implementation process, particularly in reviewing the Chief Psychiatrist Approved Forms. I look forward to welcoming more psychiatrist registrars to the Office of the Chief Psychiatrist, and I wish Dr Elcock all the best in his future employment as a Consultant Psychiatrist.

Finally, I would like to take this opportunity to acknowledge the contribution that Dr Aaron Groves made to the Tasmanian and national mental health system during his tenure as Chief Civil Psychiatrist and Chief Forensic Psychiatrist, particularly his work and passion around suicide prevention activities, leading the work of the Mental Health Integration Taskforce, (which initiated many of the state mental health reform activities currently underway) and the review of the Roy Fagan Centre-Older Persons Mental Health.

Dr Anthony Cidoni
Acting Chief Civil Psychiatrist and Chief Forensic Psychiatrist
Department of Health
12 October 2022

CHAPTER 1: BACKGROUND

The *Mental Health Act 2013* (the Act) came into effect in 2014.

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

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

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

The Act is intended to be rights-focussed, and to reflect notions of consumer autonomy. It establishes what is effectively a substitute decision-making framework for people with mental illness who, because of the illness, lack decision-making capacity and cannot make their own assessment and treatment decisions.

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

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

Before the Act commenced, decisions about treatment settings for people with severe mental illness were made by medical practitioners while decisions about treatment were commonly made by family members, carers, or friends of the person. The Act sought to address difficulties associated with this decision-making model by enabling treatment decisions to be made by an independent Tribunal comprised of legal and medical experts (the former Mental Health Tribunal, now the Tasmanian Civil and Administrative Tribunal: Protective Division: Mental Health Stream-hence force referred to as TASCAT).

Another main aim of the Act was to provide clarity for clinicians, people with experience of mental illness and their families and carers by clearly setting out the rights that consumers have under the Act.

The Act was amended in 2016 to clarify and improve the Act's operation in response to feedback received from clinicians and the Tribunal about certain aspects of the legislation. The 2016 amendments took effect on 1 July 2017.

Other more recent amendments to the Act include:

- removal of the requirement for TASCAT to review a person's admission to an approved facility before a division of three members, chosen by the Deputy President of TASCAT and
- technical amendments to the interstate transfer provision to facilitate interstate transfers of forensic patients.

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

ABOUT THE CHIEF CIVIL PSYCHIATRIST AND CHIEF FORENSIC PSYCHIATRIST

The Act provides for the offices of Chief Civil Psychiatrist and Chief Forensic Psychiatrist. As outlined in the Chief Psychiatrist message on page 5, the Act review implementation will result in these titles being merged into the statutory role of Chief Psychiatrist which will be reflected in next year's Annual Report.

The Governor may appoint a person to be Chief Civil Psychiatrist, and a person to be Chief Forensic Psychiatrist, under sections 143 and 144 of the Act respectively. In each case the person appointed must be a psychiatrist with at least five years' experience in practising psychiatry.

Together with TASCAT and Official Visitors, the Chief Psychiatrist provides an important review and oversight role.

The statutory position of Chief Forensic Psychiatrist was introduced to the *Mental Health Act 1996* in 2006. The role was widely considered to provide an important review role in relation to forensic mental health patients, and to be of value in providing an oversight and quality assurance role.

The *Mental Health Act 1996* did not provide for a similar position with respect to involuntary patients and the office of Chief Civil Psychiatrist was included in the Act to address this perceived deficiency.

The legislation in place in other States and Territories provides for the concept of Chief Psychiatrists. The concept is supported by the Model Mental Health Legislation, according to which the Chief Psychiatrist would be "responsible for the medical care and welfare of persons receiving treatment and care at a mental health facility or from a health care agency". The establishment of an independent statutory authority to provide guidance and clarity to clinical staff in relation to the Act and to oversee clinical practice in this respect was also considered to be consistent with (the then recent establishment of) independent and separate Tasmanian Health Organisations.

Matters relevant to the Chief Psychiatrists are provided for in sections 143 – 153 of the Act.

Matters relating to the offices of Chief Civil Psychiatrist and Chief Forensic Psychiatrist are set out in Chapter 2 of this document while the Chief Civil Psychiatrist and Chief Forensic Psychiatrist's powers and functions, and their oversight and review responsibilities, are explored further in Chapters 3 and 4.

The independent statutory offices of Chief Civil Psychiatrist and Chief Forensic Psychiatrist are established under sections 143 and 144 of the Act.

Each of the Chief Psychiatrists is appointed by the Governor and holds office for a term of up to five years.

Dr Aaron Groves was appointed to be Chief Civil Psychiatrist and Chief Forensic Psychiatrist on 20 November 2017 for a term of five years commencing on 23 November 2017. Dr Anthony Cidoni, Deputy Chief Psychiatrist, is currently the acting Chief Psychiatrist.

CHAPTER 2: CHIEF CIVIL PSYCHIATRIST DATA

This Chapter provides information on the offices of Chief Civil Psychiatrist and Chief Forensic Psychiatrist, and on administration of the *Mental Health Act 2013* (the Act).

APPROVED PERSONNEL

The Act provides for approved medical practitioners, approved nurses and mental health officers in Sections 138 and, 139 of the Act.

For the period 1 July 2021 to 30 June 2022:

- 84 people were reviewed and-approved as medical practitioners for purposes of the provisions of the Act within the Chief Psychiatrists' jurisdiction
- No additional classes of people were approved as medical practitioners for the purposes of the provisions of the Act within the Chief Psychiatrists' jurisdiction
- No approvals of a person as a medical practitioner were revoked
- 10 people were approved as nurses for provisions of the Act within the Chief Psychiatrists' jurisdictions
- No additional classes of people were approved as nurses for the purposes of relevant provisions of the Act
- 99 ambulance officers were newly approved as mental health officers for the Act
- 73 people other than ambulance officers were newly approved as mental health officers for the Act.

AUTHORISED PERSONS

Section 109 of the Act provides for authorisation of persons or a member of a class of persons.

Authorised persons have a range of powers and functions under the Act relating to forensic patients. This includes the power to:

- Transport an involuntary patient from an approved hospital to a secure mental health unit in relevant circumstances
- Transport a forensic patient from a secure mental health unit to an approved hospital, secure institution, health service or premises from which a health service is provided in relevant circumstances
- Apply force to a forensic patient in certain, limited circumstances

- Perform functions relating to visitors to the secure mental health unit including requiring a person seeking entry to the unit to provide proof of identity or status, and
- Perform functions in relation to telephone calls and mail to and from forensic patients.

For the period 1 July 2021 to 30 June 2022:

- No additional people were authorised under section 109 of the Act.

APPROVED FORMS

Each of the Chief Psychiatrists has the power to approve forms for use under provisions of the Act within his or her jurisdiction, or under provisions of other Acts in respect of which he or she may have responsibilities.

In the period 1 July 2021 – 30 June 2022, no new forms were approved.

A list of forms that have been approved by the Chief Civil Psychiatrist and Chief Forensic Psychiatrist since the Act's commencement in 2014, and that were in place on 30 June 2021 can be found at Appendix 1.

As part of the review implementation project, these approved forms will be reviewed and updated, and a working group has been established to guide this work.

STANDING ORDERS AND CLINICAL GUIDELINES

Clinical Guidelines and Standing Orders indicate how a provision of the Act, or another Act, should be applied in a practical clinical or forensic setting.

Each of the Chief Psychiatrists may issue Clinical Guidelines and Standing Orders to help controlling authorities, medical practitioners, nurses, or other people in the exercise of their responsibilities in respect of any treatment, clinical procedure, or other clinical matter under provisions of the Act within the relevant Chief Psychiatrist's jurisdiction, or under provisions of other Acts in respect of which the Chief Psychiatrist may have responsibilities. The power to do so is set out in section 151 of the Act.

For the period 1 July 2020 – 30 June 2021, no new Standing Orders were issued.

For the period 1 July 2020 - 30 June 2021, no new Clinical Guideline were issued.

A list of Standing Orders and Clinical Guidelines introduced by the Chief Civil Psychiatrist and the Chief Forensic Psychiatrist since the Act's commencement in 2014, and in place as of 30 June 2020 can be found at Appendix 2.

As part of the Acts review implementation process, these Standing Orders and Clinical Guidelines are in the process of being reviewed, updated, and condensed and will be available on the Chief Psychiatrist website once finalised.

STATEMENTS OF RIGHTS

Each of the Chief Psychiatrists has responsibility for approving the form of Statements of Rights required to be given to patients in relevant circumstances under the Act.

The Statements of Rights approved since the Act's commencement in 2014, and in place as of 30 June 2021 are as follows:

- *Your Rights as an Involuntary Patient – Tasmania's Mental Health Act 2013*
- *Your Rights as a Forensic Patient – Tasmania's Mental Health Act 2013*
- *Your Rights if you are Secluded or Restrained under Tasmania's Mental Health Act 2013.*

The Statements of Rights can be accessed online from here:
https://www.health.tas.gov.au/about/office-chief-psychiatrist/consumers-families-and-friends

As part of the Mental Health Act review, The Statement of Rights has been harmonised to a single statement for Involuntary and Forensic Patients.

DELEGATIONS

The Chief Psychiatrists may delegate any of their powers or functions under the Act or any other Act other than the power of delegation, the power to issue, vary or revoke Clinical Guidelines and Standing Orders and powers relating to special psychiatric treatment. The Chief Psychiatrists' power to delegate is set out in section 149 of the Act.

For the period 1 July 2020 – 30 June 2021, the Chief Civil Psychiatrist delegated certain powers and functions under the Act and the *Sentencing Act 1997* (Tas) to:

- The person or people holding particular offices or positions on five occasions
- People by name on 64 occasions.

For the period 1 July 2020 – 30 June 2021, the Chief Forensic Psychiatrist delegated certain powers and functions under the Act, the *Criminal Justice (Mental Impairment) Act 1999* (Tas), the *Corrections Act 1997* (Tas), the *Youth Justice Act 1997* (Tas), the *Criminal Code Act 1924* (Tas), the *Justices Act 1959* (Tas) and the *Sentencing Act 1997* to:

- The person or people holding offices or positions on two occasions
- People by name on 32 occasions.

The Minister for Mental Health and Wellbeing administering the Act may delegate any of his or her responsibilities under the Act other than the power or delegation and the power to approve facilities and secure institutions under sections 140 and 142 of the Act respectively. The Minister's power of delegation is set out in section 220 of the Act.

The controlling authority of an approved facility may also delegate any of the controlling authority's responsibilities under the Act or any other Act, other than the power of delegation. For approved facilities run by or on behalf of the State, the controlling authority is the Secretary, Department of Health. The controlling authority's power or delegation is set out in section 221 of the Act.

For the period 1 July 2020 – 30 June 2021, neither the Minister for Mental Health and Wellbeing nor the controlling authority delegated any of their powers and functions under the Act.

TREATMENT PLANS

Under the Act, a treatment plan is a document that outlines the treatment a patient is to receive and a copy of this must be given to the patient. A copy of the plan must also be given to the Chief Civil Psychiatrist.

A patient's treatment plan may be prepared by any medical practitioner involved in the patient's treatment or care. In preparing a treatment plan, a medical practitioner should involve and consult with the patient. The medical practitioner may also, after consulting the patient, consult with other support people as the medical practitioner considers appropriate in the circumstances. This may include the patient's family, friends, and carers.

A medical practitioner who prepares a treatment plan is required to give a copy of the plan to the patient. A copy of the plan must also be given to the Chief Civil Psychiatrist.

Table 1 shows the number of Treatment Plans made by each region over the last five years as well as the proportion who were children and breakdown by sex.

Table 1: Treatment Plans by Region

Area	2017-18	2018-19	2019-20	2020-21	2021-22
North	122	126	150	156	187
North West	167	120	135	162	195
South	374	307	356	414	437
Interstate	6	5	6	7	7
Total	**669**	**558**	**647**	**739**	**826**
% Children	1.20%	0.72%	0.77%	0.68%	0.73%
% Female (all ages)	43.35%	43.37%	42.1%	43.44%	44.19%
% Male (all ages)	56.65%	56.65%	57.81%	56.56%	55.81%

SECLUSION AND RESTRAINT

Involuntary patients may be placed in seclusion or under restraint under the Act in certain, limited circumstances. The circumstances in which an involuntary patient may be placed in seclusion or under restraint are set out in sections 56 and 57 of the Act.

Seclusion and restraint are restrictive interventions, and 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.

A person who authorises seclusion or restraint is required to make a record of the matter and to give a copy of the record to the patient, the Chief Civil Psychiatrist, and TASCAT. A copy of the record is also required to be placed on the patient's clinical record.

For the period 1 July 2021 – 30 June 2022, 16 notifications of a child being secluded were received.

There were no notifications received from the Launceston General Hospital, one notification received from the North West Regional Hospital and 15 notifications received from the Royal Hobart Hospital.

Table 2 below shows the number of people secluded by region and the breakdown by sex.

Table 2: Occasions of Seclusion by Hospital for the period 2017-18 to 2021 - 22

Area	2017-18	2018-19	2019-20	2020-21	2021-22
LGH	25	28	29	48	**35**
NWRH	17	19	18	54	**10**
RHH	91	81	105	112	**158**
MRC	3	7	3	1	**1**
Roy Fagan Centre	1	1	1	0	**0**
Total	**137**	**136**	**156**	**215**	**204**
% Female (all ages)	41.61%	44.85%	31.41%	%	**29.52**
% Male (all ages)	33.59%	58.39%	68.59%	%	**70.48**
% Other (all Ages)	0%	0%	0%	0%	**0%**

For the period 1 July 2021 – 30 June 2022, 29 notifications of a child being restrained were received. There were no notifications received from the Launceston General Hospital, three notifications received from the North West Regional Hospital, and 26 notifications received from the Royal Hobart Hospital.

Table 3 below demonstrates the occasions of restraint by hospital, the breakdown of the type of restraint used, and breakdown by sex.

Table 3: Occasions of Restraint by Hospital and Type for the period 2017-18 to 2021-22

Area	2017-18	2018-19	2019-20	2020-21	2021-22
LGH	**56**	**83**	**107**	**135**	**113**
Mechanical	5	5	6	1	17
Physical	51	73	92	134	96
Chemical	0	5	9	0	0
NWRH	**76**	**46**	**40**	**115**	**38**
Mechanical	8	9	6	7	8
Physical	65	34	33	107	29
Chemical	3	3	1	1	1
RHH	**118**	**85**	**84**	**126**	**143**
Mechanical	4	1	1	2	3
Physical	111	78	78	122	135
Chemical	3	6	5	2	5
Millbrook Rise Centre	**5**	**13**	**4**	**1**	**14**
Mechanical	0	0	0	0	1
Physical	5	12	4	1	13
Chemical	0	0	0	0	0
Roy Fagan Centre	**0**	**0**	**0**	**0**	**0**
Mechanical	0	0	0	0	0
Physical	0	0	0	0	0
Chemical	0	0	0	0	0
State Total	**255**	**227**	**235**	**377**	**308**
Mechanical	17	15	13	10	28
Physical	232	197	207	364	273
Chemical	6	15	15	3	6
Mechanical Female	41.18%	13.33%	53.85%	40.00%	14.29%
Mechanical Male	58.82%	86.67%	46.15%	60.00%	85.71%
Physical Female	56.03%	48.73%	44.44%	47.80%	50.92%
Physical Male	43.973%	51.27%	55.56%	52.20%	49.08%
Chemical Female	33.33%	40.00%	20.00%	33.33%	0.00%
Chemical Male	66.67%	60.00%	80.00%	66.67%	100.00%

STATE-WIDE RESTRICTIVE INTERVENTIONS REVIEW PANEL

The State-wide Restrictive Interventions Review Panel meets on a quarterly basis and examines all incidents of restrictive practices that have been reported to the Panel in the intervening period. The intention is to closely examine each episode to identify structural and case-specific problems and to generate discussion with a view to implementing suitable remedies to reduce these practices.

The Chief Psychiatrist is Chair of the State-wide Restrictive Interventions Review Panel.

Table 4 shows the number of seclusion events by year during the period of 2015-2021 and the breakdown by region.

Table 4: Tasmanian Seclusion Events per 1 000 Bed Days by Inpatient Unit for the Period 2017 -18 to 2021-22

Unit	2017-18	2018-19	2019-20	2020-21	2021-22
Northside	5	5.7	4.9	9.2	6.0
Spencer Clinic	5.4	5.8	4.7	10.5	1.7
RHH-Mental Health Inpatient Unit	9.5	13.6	14.7	12	15.0
Wilfred Lopes Centre	3	3.7	4.1	4.3	4.9
TOTAL	**6.4**	**8.5**	**7.6**	**8.3**	**8.7**

TRANSFER OF INVOLUNTARY PATIENTS BETWEEN HOSPITALS

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

For the period 1 July 2021 – 30 June 2022, one child was transferred twice between facilities.

Table 5 shows the number of involuntary patients transferred between facilities over the past five years by region.

Table 5: Involuntary Patient Transfers between Facilities

Originating Hospital	Destination Hospital	2017-18	2018-19	2019-20	2020-21	2021-22
LGH	RHH	1	1	0	4	5
LGH	NWRH	18	7	13	41	23
NWRH	RHH	2	0	0	2	2
NWRH	LGH	9	6	7	4	19
RHH	LGH	3	4	0	5	5
RHH	NWRH	2	2	0	1	4
Total Transfers		**35**	**20**	**20**	**57**	**58**

POWER OF DIRECT INTERVENTION

The Chief Civil Psychiatrist has the power to intervene directly regarding the assessment, treatment or care of voluntary inpatients or involuntary patients in relation to:

- The use of seclusion and restraint
- The granting, refusal, and control of leaves of absence
- The giving or withholding of patient information, and
- Assessment and treatment generally

Under the Act, a voluntary inpatient is a person who has been admitted to a facility voluntarily to receive treatment for a mental illness and is receiving that treatment with informed consent.

The power of intervention may be exercised on the Chief Civil Psychiatrist's own motion, or on request of the patient or any other person who, in the Chief Civil Psychiatrist's opinion, has a genuine interest in the patient's health, safety or welfare, and only if the Chief Civil Psychiatrist has made inquiries into the matter and is satisfied from those inquiries that intervention is essential to the patient's health, safety or welfare.

The Chief Civil Psychiatrist can exercise the power of direct intervention by giving any person responsible for the patient's treatment and care a notice to discontinue, alter, observe, or carry out a practice, procedure, or treatment in respect of the patient. The Chief Civil Psychiatrist can also issue consequential directions for the patient's future assessment, treatment, or care or direct that relevant matters be referred to TASCAT.

TASCAT has jurisdiction to review decisions made by the Chief Civil Psychiatrist under section 146 of the Act.

For the period 1 July 2020 – 30 June 2021, the Chief Civil Psychiatrist received five requests to exercise the power of direct intervention under section 147 of the Act.

In each case the Chief Civil Psychiatrist made inquiries into the relevant matters but was not satisfied from the inquiries that intervention was essential to the patient's health, safety, or welfare.

CORRECTION OF ORDERS WHERE VALIDITY NOT AFFECTED

Under section 224 of the Act, an error in a Chief Civil Psychiatrist Approved Form that does not affect the form's validity may be corrected by the Chief Civil Psychiatrist or a delegate.

For the period 1 July 2020 – 30 June 2021, the Chief Civil Psychiatrist did not correct any errors in Chief Civil Psychiatrist Approved Forms.

FUNCTIONS AND POWERS UNDER OTHER ACTS

The Chief Civil Psychiatrist has functions and powers under the *Criminal Justice (Mental Impairment) Act 1999* and the *Sentencing Act 1997*.

A full list of these functions can be found at Appendix 3.

PROTECTIVE CUSTODY

A mental health officer or police officer may take a person into protective custody under the Act if the mental health officer or police officer reasonably believes that:

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

Matters relevant to protective custody are set out in sections 17 – 21 and Schedule 2 of the Act.

Table 6 illustrates the number of people taken into protective custody by region over the last five years as well as the proportion who were children and the breakdown by sex.

Table 6: Number of People taken into Protective Custody by Region

Area	2017-18	2018-19	2019-20	2020-21	2021-22
North	126	133	125	121	111
North West	197	186	196	202	201
South	211	219	197	241	238
Interstate	10	6	4	8	3
Total	**544**	**544**	**522**	**572**	**553**
% Children	6.07%	7.17%	7.17%	8.22%	4.70%
% Female (all ages)	47.79%	46.69%	44.06%	51.75%	48.46%
%Male (all ages)	52.21%	53.31%	55.94%	48.25%	51.54%

As part of the Mental Health Act Review Implementation the term Protective Custody will be changed to Assessment Authority.

ASSESSMENT ORDERS

A medical practitioner may make an Assessment Order in respect of a person if the medical practitioner has examined the person in the 24-hour period immediately before the Assessment Order is made and is satisfied from that 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 person assessed with informed consent has failed, or that it would be futile or inappropriate to attempt to have the person assessed with informed consent.

The assessment criteria are set out in section 25

The meaning of decision-making capacity is set out in section 7 of the Act.

Matters relevant to Assessment Orders are set out in sections 22 – 35 of the Act.

For the period 1 July 2020-30 June 2021, the Chief Civil Psychiatrist received 975 Assessment Order records made by medical practitioners. This was an increase from the previous year in which 1090 Assessment Order records were received.

TREATMENT ORDERS

The treatment criteria are set out in section 40 of the Act. A patient's treating medical practitioner may seek to have an involuntary patient who has failed to comply with a Treatment Order admitted to, and if necessary detained in, an approved hospital. The circumstances in which this may occur are set out in section 47 of the Act.

Table 7 shows the number of people who were non-compliant with their Treatment Order by region over the last five years and action taken under section 47 of the Act.

Table 7: Failures to Comply with Treatment Orders – Action Taken under section 47 of the Act by Facility

Hospital	2017-18	2018-19	2019-20	2020-21	2021-22
LGH	8	3	4	1	7
NWRH	11	7	5	10	11
RHH	28	13	47	33	27
Total	**47**	**23**	**56**	**44**	**45**

A patient's treating medical practitioner may also seek to have a patient who has complied with a Treatment Order but who nevertheless requires admission to prevent possible harm taken under escort and involuntarily admitted to and detained in an approved hospital. The circumstances in which this may occur are set out in section 47A of the Act.

Table 8 below shows the number of admissions to prevent potential harm by region and action taken pursuant to section 47A of the Act.

Table 8: Admissions to Prevent Possible Harm - Action Taken under section 47A of the Act by Region

Hospital	2019-20	2020-21	2021-22
LGH	54	51	57
NWRH	21	33	21
RHH	75	71	81
Roy Fagan	1	1	4
Millbrook Rise	0	1	2
Total	**151**	**157**	**165**

URGENT CIRCUMSTANCES TREATMENT

Urgent circumstances treatment is treatment that is authorised by an approved medical practitioner as being urgently needed in the patient's best interests and that is given to the patient without informed consent or TASCAT authorisation.

The circumstances in which urgent circumstances treatment may be authorised for and given to an involuntary patient are set out in section 55 of the Act.

Table 9 below demonstrates the number of people who were authorised for urgent circumstances treatment by region over the last five years as well as the proportion who were children and the breakdown by sex.

Table 9: Authorisations of Urgent Circumstances Treatment by Region

Area	2017-18	2018-19	2019-20	2020-21	2021-22
North	321	254	274	290	274
North West	160	148	181	160	208
South	477	473	535	663	484
Interstate	12	10	9	10	11
Total	**970**	**885**	**999**	**1123**	**977**
% Children	1.75%	1.81%	2.50%	1.96%	1.02%
% Female (all ages)	49.18%	53.73%	48.35%	50.22%	51.48%
% Male (all ages)	50.10%	46.27%	51.65%	49.69%	48.52%
% Other (all Ages)	0.72%	0.00%	0.00%	0.00%	0.00%

CHAPTER 4: CHIEF FORENSIC PSYCHIATRIST DATA

The Chief Forensic Psychiatrist has the functions delegated under the Act and by other Acts, and the power to do anything necessary to perform these functions. This includes matters relating to patient leave and transfers between approved facilities, authorising seclusion, or restraint for certain patients, correcting errors in forms that do not affect the form's validity and intervening directly regarding the assessment, treatment, and care of forensic patients.

RETURN OF CERTAIN FORENSIC PATIENTS TO PRISON OR YOUTH DETENTION

The Chief Forensic Psychiatrist or a delegate is to have any patient who asks to be returned to custody, examined by an approved medical practitioner as soon as possible after receiving the patient's request. The Chief Forensic Psychiatrist or delegate must 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 that the Chief Forensic Psychiatrist or delegate thinks are relevant, before deciding whether to agree to the request, or refuse the request.

The circumstances in which a forensic patient may ask to be returned to prison or youth detention, and the actions required from the Chief Forensic Psychiatrist or delegate on receipt of such a request, are set out in section 70 of the Act.

Any decision by the Chief Forensic Psychiatrist or a delegate to refuse a request is reviewable by TASCAT.

Table 10 shows that there have been no requests received to return patients to prison or youth detention over the past 5 years.

Table 10: Requests to Return to Prison/Youth Detention

	2017-18	2018-19	2019-20	2020-21	2021-22
Request to return to prison	0	0	0	0	0
% Female (all ages)	0.00%	0.00%	0.00%	0.00%	0.00%
% Male (all ages)	0.00%	0.00%	0.00%	0.00%	0.00%

TRANSFER OF FORENSIC PATIENTS TO HOSPITALS

The Chief Forensic Psychiatrist may direct that a forensic patient be removed from a secure mental health unit and transferred to a secure institution, an approved hospital, a health service within the meaning of the *Health Complaints Act 1995* (Tas), or premises where such a health service is provided. Section 73 regulates transfers of this kind.

Circumstances in which a transfer may be directed under section 73 of the Act include if a patient requires specialist hospital care or to facilitate attendance at allied health, dental or medical appointments which generally occur offsite.

In most cases transfers are planned and authorisation is given by a delegate of the Chief Forensic Psychiatrist.

Table 11 below illustrates the number of forensic patient transfers to hospitals over the last five years and the breakdown by sex.

Table 11: Forensic Patient transfers to Hospital etc

	2017-18	2018-19	2019-20	2020-21	2021-22
Transfer to hospital	35	32	148	91	44
% Female (all ages)	0.00%	6.25%	0.00%	1.10%	0.00%
% Male (all ages)	100.00%	93.75%	100.00%	98.90%	100.00%

LEAVE OF ABSENCE

The Chief Forensic Psychiatrist or a delegate may:

- Apply to the TASCAT, under section 78 of the Act, for leave of absence for a forensic patient who is subject to a restriction order
- Apply to TASCAT, under section 79 of the Act, for an extension of leave or variation of the conditions of leave that has been granted to a forensic patient who is subject to a restriction order under section 78 of the Act
- Cancel leave, under section 79 of the Act, that has been granted to a forensic patient under section 78 of the Act
- Grant leave of absence, under section 82 of the Act, to a forensic patient who is not subject to a restriction order
- Extend, vary, or cancel leave, under section 83 of the Act, that has been granted to a forensic patient who is not subject to a restriction order.

Table 12 shows the number of forensic patients who were not on Restriction Orders who were approved for leave and the breakdown by sex.

Table 12: Leave of Absence Granted to Forensic Patients who are not subject to Restriction Orders

	2017-18	2018-19	2019-20	2020-21	2021-22
Leave of Absence	37	4	17	6	34
% Female (all ages)	0.00%	0.00%	0.00%	0.00%	0.00%
% Male (all ages)	100.00%	100.00%	100.00%	100.00%	100.00%

SECLUSION AND RESTRAINT

Forensic patients may be placed in seclusion or under restraint pursuant to the Act in certain, limited circumstances. The circumstances in which a forensic patient may be placed in seclusion or under restraint are set out in sections 94 and 95 of the Act respectively.

Table 13 illustrates the number of seclusion authority forms received by the Chief Forensic Psychiatrist over the past five years and the breakdown by sex.

Table 13: Number of seclusion authority forms received by the Chief Forensic Psychiatrist

Hospital	2017-18	2018-19	2019-20	2020-21	2021-22
Seclusion	7	6	16	28	23
% Female (all ages)	0.00%	0.00%	6.25%	3.57%	4.35%
% Male (all ages)	100.00%	100.00%	93.75%	96.43%	95.65%

No new means of restraint were approved by the Chief Forensic Psychiatrist during the 2021 –2022 Financial Year.

CANCELLATION OR SUSPENSION OF PRIVILEGED VISITOR, CALLER OR CORRESPONDENT STATUS

The Act provides forensic patient with certain visiting, telephone, and correspondence rights. These are provided for in sections 97 – 107 of the Act.

For the period 1 July 2021 – 30 June 2022, the Chief Forensic Psychiatrist did not cancel or suspend any individual's privileged visitor, privileged caller, or privileged correspondent status.

POWER OF DIRECT INTERVENTION

The Chief Forensic Psychiatrist has the power to intervene directly regarding the assessment, treatment, or care of forensic patients in relation to:

- The use of seclusion or restraint
- The use of force
- The granting, refusal, and control of leaves of absence
- The giving or withholding of patient information
- The granting, denial, and control of visiting, correspondence, and telephone rights
- Assessment and treatment generally, and
- Matters prescribed by the regulations.

It should be noted that no matters are prescribed by the regulations.

The power of direct intervention may be exercised on the Chief Forensic Psychiatrist's own motion, or on request of the patient or any other person who, in the Chief Forensic Psychiatrist's opinion, has a genuine interest in the patient's health, safety or welfare, and only if the Chief Forensic Psychiatrist has made inquiries into the matter and is satisfied from those inquiries that intervention is essential to the patient's health, safety or welfare.

The Chief Forensic Psychiatrist can exercise the power of direct intervention by giving any person responsible for the patient's treatment and care a notice to discontinue, alter, observe, or carry out a practice, procedure, or treatment in respect of the patient. The Chief Forensic Psychiatrist can also issue consequential directions for the patient's future assessment, treatment, or care or direct that relevant matters be referred to TASCAT.

The Chief Forensic Psychiatrist cannot however issue directions which are repugnant to any provision of the Act or of any other Act, or to an order, determination, or direction of TASCAT or any Court. This effectively prevents the Chief Forensic Psychiatrist from using the power of direct intervention to achieve an outcome that would be contrary to the provisions, including the objects and principles, of the Act.

TASCAT has jurisdiction to review decisions made by the Chief Forensic Psychiatrist under section 146 of the Act.

For the period 1 July 2021 – 30 June 2022, one application was made to the Chief Forensic Psychiatrist who did not exercise the power of direct intervention.

CORRECTION OF ORDERS WHERE VALIDITY NOT AFFECTED

Under section 224 of the Act, an error in a Chief Forensic Psychiatrist Approved Form that does not affect the form's validity may be corrected by the Chief Forensic Psychiatrist or a delegate.

For the period 1 July 2021 – 30 June 2022, the Chief Forensic Psychiatrist did not correct any errors in Chief Forensic Psychiatrist approved forms.

FUNCTIONS AND POWERS UNDER OTHER ACTS

The Chief Forensic Psychiatrist has functions and powers under the *Criminal Justice (Mental Impairment) Act 1999*, *Corrections Act 1997*, *Youth Justice Act*, *Criminal Code Act*, *Justices Act*, and the *Sentencing Act*.

A full list of these functions can be found at Appendix 4.

A main function of the Chief Forensic Psychiatrist under the *Criminal Justice (Mental Impairment) Act*, *Corrections Act*, *Youth Justice Act*, *Criminal Code Act*, *Justice Act 1997*, and the *Sentencing Act 1997* is to provide reports to Courts and other bodies. In most cases reports are prepared in practice by delegates of the Chief Forensic Psychiatrist.

Data relating to reports that have been requested in the 2021 – 2022 Financial Year and in previous Financial Years is reported below in Table 14.

Table 14: Number of reports requested from the Chief Forensic Psychiatrist

	2017-18	2018-19	2019-20	2020-21	2021-22
Reports Requested	15	15	9	21	23

URGENT CIRCUMSTANCES TREATMENT- FORENSIC

Urgent circumstances treatment is treatment that is authorised by an approved medical practitioner as being urgently needed in the patient's best interests and that is given to the patient without informed consent or TASCAT authorisation.

For the period 1 July 2021 – 30 June 2022, there was one authorisation of urgent circumstances treatment for a forensic patient.

ADMISSION OF INVOLUNTARY PATIENTS TO SECURE MENTAL HEALTH UNITS

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

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

The criteria for transfer to a secure mental health unit are being reviewed as part of the Mental Health Act Review and will be moving towards a security-based assessment. TASCAT has oversight of the admission, and any extension of the period of admission, of an involuntary patient to a secure mental health unit.

Table 15 shows the number of admissions of involuntary patients to secure mental health units over the past five years and the breakdown by sex.

Table 15: Admissions of Involuntary Patients to Secure Mental Health Units (SMHU)

	2017-18	2018-19	2019-20	2020-21	2021-22
Involuntary patient transfer to SMHU	1	3	1	5	1
% Female (all ages)	0.00%	0.00%	0.00%	0.00%	100.00%
% Male (all ages)	100.000%	100.00%	100.00%	100.00%	0.00%

CHAPTER 4: STATE CONTEXT

FUNDING AND SERVICE DELIVERY

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

Public sector mental health services and forensic services are provided across Tasmania through the Tasmanian Health Service (THS) Services include:

- 24-hour acute inpatient services located at three public hospitals (the Royal Hobart Hospital Mental Health Inpatient Unit and Mental Health Short Stay Unit the Launceston General Hospital Northside Clinic, and the North West Regional Hospital Spencer Clinic - Burnie Campus)
- a 24-hour older persons acute/sub-acute inpatient unit located in the South providing services to people across the state (the Roy Fagan Centre)
- a 24-hour extended treatment and residential rehabilitation facility located in the South (Mistral Place)
- 24-hour specialist extended treatment units located in the South and providing services to people across the state (the Millbrook Rise Centre and Tolosa Street)
- The Mental Health Hospital in the Home Unit
- The Mental Health Homeless Outreach Support Team (MHHOST)
- The Mental Health Co Response Service (PACER)
- The Clozapine Clinic at the Royal Hobart Hospital
- A Consultant Liaison Service in each of the three regions
- child and adolescent, older persons and adult community mental health services that operate throughout the state
- adult community mental health teams that provide crisis, assessment and treatment and triage services
- a 24-hour state-wide helpline and triage service – Access Mental Health, and

- community and inpatient care for people with a mental illness who are involved with, or who are a risk of involvement with, the justice system (community forensic mental health services teams, the Defendant Health Liaison Service and the Wilfred Lopes Centre).

The Tasmanian Government also funds a range of community-based organisations to provide services including:

- psychosocial support services (for people not eligible for the National Disability Insurance Scheme)
- individual packages of care
- residential rehabilitation
- community-based recovery and rehabilitation
- peer support groups
- prevention and brief intervention services, and
- advocacy and peak body representation for consumers, carers, and service providers.

The Tasmanian public mental health service is primarily designed to provide a range of clinical services to people living with the most severe forms of mental illness.

CHAPTER 5: KEY ISSUES

MENTAL HEALTH ACT REVIEW IMPLEMENTATION PROJECT

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

The Minister is also required under section 229 of the *Mental Health Act 2013* to deliver a report on the outcome of the review to be tabled in each House of Parliament within 10 sitting-days of each House after the review is completed.

The review of the Act is necessary to satisfy the requirements of Section 229 of the Act.

The review also provided a mechanism for:

- satisfying stakeholder expectations that the Act's operation will be reviewed
- facilitating feedback from stakeholders on aspects of the Act's operation that impact on or concern them, and
- enabling issues with the Act's operation to be identified and conveyed to the Minister for Mental Health and Wellbeing and the Minister for Justice, and for those issues to be reported to the Tasmanian Parliament.

The outcome review recommendations were accepted, and the final report published by the Tasmanian Government in June 2020. The Outcome Report recommendations have been accepted by the Tasmanian Government for implementation across two tranches during 2022 and 2023.

The Office of the Chief Psychiatrist is responsible for the implementation of the 29 review recommendations. The Mental Health Act Review Implementation project is in direct response to the Review Outcomes report and the associated 29 recommendations.

The project formally commenced in late 2021 with the appointment of a Project Manager and a Project Officer to coordinate the project actions. The project governance includes a project Steering Committee and topic specific working groups relating to legislation amendments, forms and documents, and training and education outcomes. The project governance includes people with lived experience, their families, and their friends.

The key focus of the project is to implement the 29 recommendations from the Review Outcomes report. The Review process involved broad consultation with stakeholders during 2019-2020. The review process included formal reference consultation groups to inform the recommendations outlined in the Review Outcomes Report.

The review outcomes recommendations cover three broad areas:

1. Legislative reform
2. Forms and processes
3. Training and workforce development.

The objective(s) of the *Mental Health Act 2013* Reform Implementation Project are:

- To implement the 29 Review Outcomes in a way that aligns with the *Mental Health Act 2013* reform intent
- To ensure that the Act continues to provide a contemporary framework for the people living with severe mental illness and who do not have capacity to decide about assessment or treatment for themselves. This must continue to occur in a way that places the patient at the centre of the decision making for suitable and necessary treatment and ensures the patient's rights are upheld, and
- Ensure the Act promotes priorities identified as the building blocks for ongoing reform being:
    - Priority 1: promote person-centred approaches
    - Priority 2: Improve the mental health and social and emotional wellbeing of all Australians
    - Priority 3: Prevent mental illness
    - Priority 4: Focus on early detection and intervention
    - Priority 5: Improve access to high quality services and supports
    - Priority 6: Improve the social and economic participation of people with mental illness.

Tranche 1 includes the more straightforward legislative amendments and related actions with tranche 2 actioning the more complicated legislative amendments. Ongoing training and development actions have been identified to ensure that those delegated under the Act have easy access to relevant information in plain language. Project deliverables will include a plain language guide to assist with interpretation of the *Mental Health Act 2013*.

It is intended that the legislative amendments and associated project actions will assist to make the *Mental Health Act 2013* easier to understand and interpret and will include improved patient rights and principles with the aim of improving treatment and care for involuntary patients under the Act in Tasmania.

MENTAL HEALTH TREATMENT FOR PEOPLE WHO HAVE AN INTELLECTUAL DISABILITY AND MENTAL ILLNESS WHO ARE NOT ABLE TO CONSENT TO THEIR TREATMENT AND CARE.

In August this year a roundtable discussion requested by the Tasmanian branch of the Australian Medical Association (AMA) was held with Statewide Mental Health Services representatives, the AMA, General Practitioners, the Office of the Public Guardian, the Senior Practitioner, and the Office of the Chief Psychiatrist to explore longer term pathways for the management of people with an intellectual disability and mental illness (who are not able to consent to their mental health treatment).

This has been an emerging policy issue in Tasmania that requires careful consideration and acknowledgement that this group of people are highly vulnerable and have complex needs and it is imperative that they have the appropriate safeguards and protection in place to ensure their rights and best interests are upheld.

The outcome from this roundtable was that no changes to existing legislation will be made, and no new legislation will be introduced, but instead, guidelines will be developed to better articulate when consent to mental health assessment and treatment can be made by a Guardian pursuant to the *Guardianship and Administration Act 1995*, when people need to be treated under the *Mental Health Act 2013* and the interaction between the two Acts. This work will be led by the Office of the Chief Psychiatrist with input from all the relevant parties.

PROTECTIVE CUSTODY

Sections 17-21 of the Mental Health Act regulates the administration of protective custody for a mental health officer or a police officer if they believe that a person may have a mental illness that requires an assessment in the best interests of their safety and that of other persons. The Office of the Chief Psychiatrist has been reviewing protective custody incidents and the associated documentation-protective custody form 4 an approved form under the Act.

The review found that there are occasions where the four-hour period that a person can be held in protective custody has lapsed prior to a person been placed under an assessment order. It has also been identified that on occasions, Form 4 is not completed as required under the Mental Health Act. Further work with our services to ensure compliance with the Mental Health Act will be undertaken over the coming months. This will also align with the work of the Mental Health Act review implementation team in terms of updating the Approved Forms, providing education to clinicians around the application of the Act and the proposed amendments to the Act which will see changes to the protective custody timeframe requirements.

LIVED EXPERIENCE ADVISORY GROUP (LEAG)

The Lived Experience Advisory Group has not been able to meet as frequently as expected. The LEAG met in September 2022, and a minimum of quarterly meetings will be scheduled following that as this group has an important advisory function to the Office of the Chief Psychiatrist around policy, legislation, and service development activities. More work will be undertaken with this group in the next reporting period to ensure their skills and expertise are being fully utilised to support the future work of the Office of the Chief Psychiatrist, including increased input into the Mental Health Act Review implementation process.

YOUR SAY ADVOCACY TASMANIA

The Department of Health funds Your Say Advocacy Tasmania to provide a Mental Health Tribunal Representation Scheme (MHTRS) for people listed for TASCAT hearings. Your Say Advocacy Tasmania provided a submission to the Minister for Mental Health and Wellbeing in March this year about the Mental Health Tribunal Representation Scheme in the context of better supporting people to exercise their rights if they might be subject to compulsory treatment under the Mental Health Act. The report recommends a proposal for legislative reform in Tasmania to make amendments to *Mental Health Act 2013* to allow for the disclosure of information to the MHTRS about people been listed for TASCAT hearings consistent with the Royal Commission into Victoria's Mental Health System recommendation for an opt-out mechanism which would see names and contact information of people listed for Tribunal hearings provided to non-legal advocacy services prior to hearings, without the persons consent.

It is a very important principle of mental health treatment that people being assessed and treated under the *Mental Health Act 2013* have prompt and universal access to advocacy support services. However, it is not feasible to implement an opt-out system that simply provides the Mental Health Tribunal Representation Scheme with patients' contact details at the Tribunal stage. Such a model may not advance the key strengths of non-legal advocacy services and is inconsistent with processes and progress occurring in other jurisdictions, including the recommendations of the Royal Commission into Victoria's Mental Health System.

The Office of the Chief Psychiatrist supports the retention of an opt-in system, whereby the person has a choice in relation to the provision of their personal contact details to advocacy services, rather than an opt-out system whereby personal contact details are disclosed to advocacy services without their direct consent. Further work will be undertaken in the coming months with Your Say Advocacy and TASCAT to improve accessibility to patient advocacy services that do not impinge on patient's privacy and build on the proposed amendments as part of the Mental Health Act review implementation to strengthen and ensure contemporaneity of people's rights and improve information accessibility.

TASMANIAN LAW REFORM INSTITUTE'S (TLRI) FINAL REPORT- SEXUAL ORIENTATION AND GENDER IDENTITY (SOGI) CONVERSION PRACTICES: UPDATE ON TASMANIAN GOVERNMENT RESPONSE

In January 2021, the Chief Psychiatrist provided a submission into the TLRI review of Sexual Orientation and Gender Identity (SOGI) conversion practices in Tasmania. SOGI conversion practices involve conduct that aims to change, suppress, or eradicate the sexual orientation or gender identity/expression of another person. This includes subjecting a person to 'therapy', 'counselling', or 'treatment' to change who they are attracted to, or how they feel about or express their gender to others. The submission to the TLRI was that the Chief Psychiatrist did not support the use of SOGI practices in any settings in Tasmania, whether this be in a clinical or non-clinical environment, and that a person should not be considered to have a mental illness or disorder due to their gender identity preference or expression.

The view of the Chief Psychiatrist is that the Mental Health Act is not the appropriate legal framework to prohibit, investigate or regulate SOGI practices.

The TLRI Final Report, publicly released on 16 May 2022, found Tasmanian law does not currently adequately define, prohibit, or regulate SOGI conversion practices. It makes 16 recommendations concerning amendments to existing legislation and action to end SOGI conversion practices in Tasmania. The report has received significant media and public attention.

The reforms proposed in the TLRI Final Report call for significant law reform across Tasmanian Government agencies. The Tasmanian Government is yet to make a formal response to the TLRI Final Report; however, a sensitive and balanced approach is required around the implementation of the proposed recommendations.

The Department of Health in supporting the policy intent of the recommendations, have had discussions with key government stakeholders to inform appropriate options for implementing the intent of the recommendations in the Tasmanian context, and the appropriate legislative frameworks to do address these. The Department of Health is working closely with the Department of Justice to undertake this important work.

APPENDIX 1: APPROVED FORMS

The forms approved by the Chief Civil Psychiatrist since the Act's commencement in February 2014 and that were in place on 30 June 2021 are as follows:

- Decision-making capacity (CCP Approved Forms 2A and 2B)
- Protective Custody (CCP Approved Form 4)
- Assessment Orders (CCP Approved Form 6)
- Treatment Plans (CCP Approved Form 7)
- Urgent Circumstances Treatment (Involuntary Patients) (CCP Approved Form 8)
- Seclusion (Involuntary Patients) (CCP Approved Form 9)
- Restraint (Involuntary Patients) (CCP Approved Form 10)
- Leave (Involuntary Patients) (CCP Approved Forms 11, 12A, 12B and 12C)
- Involuntary Patient Transfer Between Hospitals (CCP Approved Form 13)
- Admission of an involuntary patient to hospital following failure to comply with a Treatment Order (CCP Approved Form 22)
- Admission of an involuntary patient to hospital to prevent possible harm (CCP Approved Form 23)
- Involuntary Patient Escort to Hospital (CCP Approved Form 24).

The forms approved by the Chief Forensic Psychiatrist since the Act's commencement in February 2014 and that were in place on 30 June 2021 are as follows:

- Urgent Circumstances Treatment (Forensic Patients) (CFP Approved Form 8)
- Seclusion (Forensic Patients) (CFP Approved Form 9)
- Restraint (Forensic Patients) (CFP Approved Form 10)
- Leave (Forensic Patients) (CFP Approved Forms 12A, 12B and 12C)
- Search and Seizure (CFP Approved Form 16)
- Forensic Patient Transfer to Hospital (CFP Approved Form 17)
- Cancellation or Suspension of Visits (CFP Approved Form 18)
- Forensic Patient Request to Return to Prison/Youth Detention (CFP Approved Forms 20A and 20B).

APPENDIX 2: STANDING ORDERS AND CLINICAL GUIDELINES

The following Standing Orders issued by the Chief Civil Psychiatrist were in place as of 30 June 2021:

- Chief Civil Psychiatrist Standing Order 8 - Urgent Circumstances Treatment
- Chief Civil Psychiatrist Standing Order 9 – Seclusion
- Chief Civil Psychiatrist Standing Order 10 - Chemical Restraint
- Chief Civil Psychiatrist Standing Order 10A - Mechanical Restraint and Physical Restraint

The following Standing Orders issued by the Chief Forensic Psychiatrist were in place as of 30 June 2021:

- Chief Forensic Psychiatrist Standing Order 8 - Urgent Circumstances Treatment
- Chief Forensic Psychiatrist Standing Order 9 - Seclusion
- Chief Forensic Psychiatrist Standing Order 10 - Chemical Restraint
- Chief Forensic Psychiatrist Standing Order 10A - Mechanical Restraint and Physical Restraint
- Chief Forensic Psychiatrist Standing Order 15 - Visitor Identification
- Chief Forensic Psychiatrist Standing Order 16 – Entry Screen and Search
- Chief Forensic Psychiatrist Standing Order 17 – Unauthorised Items
- Chief Forensic Psychiatrist Standing Order 21 – Use of Force.

The Chief Civil Psychiatrist and Chief Forensic Psychiatrist have issued one joint Standing Order - Standing Order 19 – Involuntary Patient Admission to Secure Mental Health Unit.

The following Clinical Guidelines issued by the Chief Civil Psychiatrist were in place as of 30 June 2021:

- Chief Civil Psychiatrist Clinical Guideline 1 – Meaning of Mental Illness
- Chief Civil Psychiatrist Clinical Guideline 7 – Off-Label Use of Medications
- Chief Civil Psychiatrist Clinical Guideline 8 - Urgent Circumstances Treatment
- Chief Civil Psychiatrist Clinical Guideline 9 – Seclusion
- Chief Civil Psychiatrist Clinical Guideline 10 – Chemical Restraint
- Chief Civil Psychiatrist Clinical Guideline 10A - Mechanical Restraint and Physical Restraint.

The following Clinical Guidelines issued by the Chief Forensic Psychiatrist were in place as of 30 June 2021:

- Chief Forensic Psychiatrist Clinical Guideline 8 – Urgent Circumstances Treatment
- Chief Forensic Psychiatrist Clinical Guideline 9 – Seclusion
- Chief Forensic Psychiatrist Clinical Guideline 10 – Chemical Restraint
- Chief Forensic Psychiatrist Clinical Guideline 10A – Mechanical Restraint and Physical Restraint.

The Chief Civil Psychiatrist and Chief Forensic Psychiatrist have issued several joint Clinical Guidelines, as follows:

- Chief Civil Psychiatrist and Chief Forensic Psychiatrist Clinical Guideline 2 – Capacity
- Chief Civil Psychiatrist and Chief Forensic Psychiatrist Clinical Guideline 3 – Representative and Support Person.
- These Approved Forms, Clinical Guidelines and Standing Orders are being reviewed by the Mental Health Act Review Forms and Working Group and will be updated and made available in the next reporting period.

APPENDIX 3: CHIEF CIVIL PSYCHIATRIST - POWERS AND FUNCTIONS UNDER OTHER ACTS

The Chief Civil Psychiatrist has the following powers and functions under the *Criminal Justice (Mental Impairment) Act 1999* and the *Sentencing Act 1997:*

- Notifying the Attorney General of a defendant's subsequent fitness to stand trial under section 29 of the *Criminal Justice (Mental Impairment) Act 1999*
- Receiving notification that no further proceedings are to be taken against a defendant from the Attorney-General under section 29 of the *Criminal Justice (Mental Impairment) Act 1999*
- Reporting to the Court under section 75 of the *Sentencing Act 1997*.

APPENDIX 4: CHIEF FORENSIC PSYCHIATRIST - POWERS AND FUNCTIONS UNDER OTHER ACTS

The Chief Forensic Psychiatrist has powers and functions under the *Criminal Justice (Mental Impairment) Act 1999,* the *Sentencing Act 1997*, the *Criminal Code Act 1924*, the *Corrections Act 1997,* and the *Youth Justice Act1997*.

The Chief Forensic Psychiatrists under the *Criminal Justice (Mental Impairment) Act 1999* 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 TASCAT 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 a secure mental health unit 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, and
- Authorising persons under section 41A.

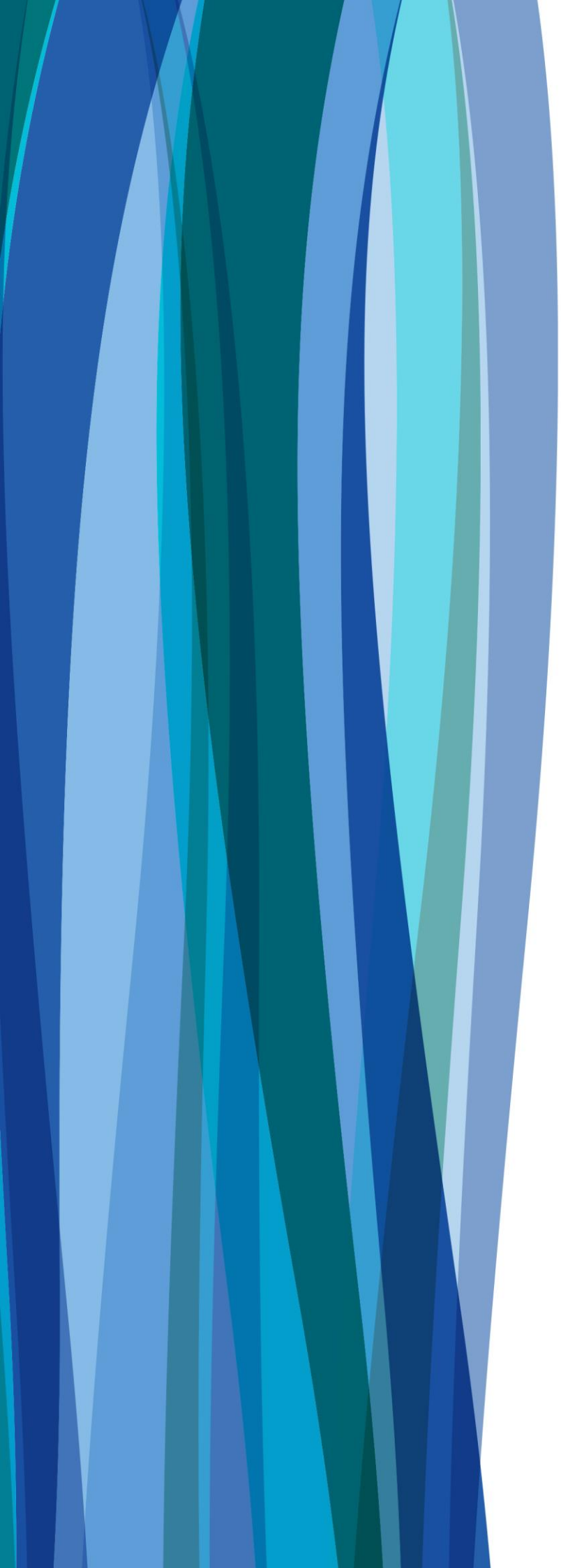
The Chief Forensic Psychiatrist's functions under the *Sentencing Act* are to provide advice to the Court under section 72 and to report to the Court under section 75.

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 secure mental health unit under section 36A, to require the Director, Corrective Services, to remove a prisoner or detainee who has been admitted to the secure mental health unit from the secure mental health unit 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 secure mental health unit under section 134A, and
- Requiring the Secretary, Youth Justice to remove a youth detainee from the secure mental health unit under section 134A.



Tasmanian Government

Office of the Chief Psychiatrist
Department of Health

GPO Box 125
Hobart TAS 7001

03 6166 0778

chief.psychiatrist@health.tas.gov.au

www.health.tas.gov.au