# ANNUAL REPORT

# 2022 - 2023

CHIEF CIVIL PSYCHIATRIST

CHIEF FORENSIC PSYCHIATRIST

Office of the Chief Psychiatrist
Department of Health

Tasmanian Government

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# 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 2022 – 30 June 2023.

I begin by acknowledging the original custodians of Tasmania (Iutruwita), the palawa people, and pay my respects to elders, past, present and emerging and signal my strong commitment to Closing the Gap.

I would also like to recognise the knowledge and wisdom of people with a lived and living experience of mental health, their families and friends, and commit to ensuring that the voice of lived experience is heard in all of the work that we do, as we collaborate and co-produce to improve the mental health of consumers. I wish to thank the Chief Psychiatrist's Lived Experience Advisory Group. My Office values the perspectives and experience the group brings to our work.

This report is my second as the Acting Chief Civil Psychiatrist and Acting Chief Forensic Psychiatrist for Tasmania and provides an outline of the Chief Psychiatrists' activities during the 2022-23 Financial Year. It reports on the statutory functions of the Chief Psychiatrists under the Act and makes observations and presents data about these 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 with the Mental Health Amendment Bill 2022 having been accepted in both Houses of Parliament and with a range of amendments due to commence from 25 September 2023. These Tranche 1 amendments will include the establishment of a single title of Chief Psychiatrist (replacing Chief Forensic and Chief Civil Psychiatrist roles), strengthening the provisions relating to children, changes to patient leave to remove the requirement for an application form, improvements to safeguarding and oversight supported by the expansion of Official Visitor powers, changes to seclusion and restraint timeframes, and changes to the Protective Custody title. All the Chief Civil Psychiatrist and Chief Forensic Psychiatrist approved forms, standing orders and clinical guidelines will be updated to align with the Tranche 1 implementation with some forms being condensed to make them more user friendly for patients, clinicians and families and friends.

The Office of the Chief Psychiatrist is developing a range of training materials and online educational resources to communicate the Tranche 1 implementation.

The work to date has required enormous effort from our working group, sub-committee and steering Committee members who have continued to devote time out of their busy schedules to get us to this point. I would like to thank our partners from Flourish Tasmania, Mental Health Family and Friends Tasmania, our Lived Experience Advisory Group, the Tasmanian Civil and Administrative Tribunal (TASCAT), Department of Health (DoH) Legal Services, Department of Justice, and Legal Aid Tasmania who have been instrumental in supporting the roll out of the Tranche 1 implementation phase, and I look forward to continuing to work with these stakeholders as we progress Tranche 2 of the implementation phase. More details about the *Mental Health Act 2013* review implementation are provided under Chapter 5 of this report.

The Chief Psychiatrist participates in a wide range of state and national committees, including the Combined Peak and Government Closing the Gap Policy Partnership, the Tasmanian Medication Access Advisory Committee (chairing the Tasmanian Psychotropic Medicines Subcommitee), chairing the Statewide Seclusion and Restraint Oversight Committee, the Beyond Blue board and the federal Quality and Safety Committee.

The Tasmanian Mental Health Reform Program (TMHRP) continues to transform our public mental health services, implementing new models of care and major infrastructure development with an initial focus on southern Tasmania. In March 2023 the redeveloped Peacock Centre officially opened providing a 12-bed short stay unit, a Mental Health Integration Hub bringing together a range of community based organisations to provide mental health and wellbeing support, a Safe Haven supporting people in suicidal distress and their families and support people in a home-like supportive environment, and a Recovery College classroom providing personal recovery through an educative approach for people to improve their mental health and wellbeing.

The Peacock Centre is unique in that it provides a range of contemporary and capacity building mental health and wellbeing supports with the overall aim of avoiding people in mental health distress needing to present at the emergency department and supporting them in a home-like environment where appropriate. There are peer workers employed within a multidisciplinary team creating a rich and diverse workforce in these new models of care.

Planning for the next stage of development is underway with a second mental health centre to be built at St Johns Park in 2025 which will provide another Safe Haven, 15 short-stay beds and another Mental Health Integration Hub, co-located with the new Statewide Tasmanian Eating Disorder Service.

This year has seen the setting up of the Premier's Mental Health and Suicide Prevention Advisory Council, of which I am member. This is a very important initiative to drive mental health and suicide prevention reform and oversee the implementation of the Tasmanian Suicide Prevention Strategy 2023-2027.

I would like to also take this opportunity 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 would like to acknowledge that the work of the Chief Psychiatrist has been assisted by close working relationships with Statewide Mental Health Services (SMHS), TASCAT, Mental Health Official Visitors Scheme, the Public Guardian, the Office of the Health Complaints Commission, the Commissioner for Children and Young People 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 like to thank Dr Bension Elijah, Executive Director of Medical Services and Ms Catherine Schofield, Executive Director of Nursing of SMHS for their collaboration. Also, I would like to acknowledge the work of the clinicians, support staff and service leaders who continue to share their expertise and experience with us and provide essential input and insight as new initiatives, reforms and policies are implemented locally and nationally.

And finally, thank you to those with lived experience who motivate us to improve the health and wellbeing of Tasmanians.

Associate Professor Anthony Cidoni
Acting Chief Psychiatrist
Department of Health
29 September 2023

# CHAPTER 1: BACKGROUND

The *Mental Health Act 2013* (the Act) came into effect in 2014, with the first tranche of changes resulting from its review due to come into effect on 25 September 2023.

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 holds 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 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 Rights and Service Principles have been extensively reviewed and updated as part of the Mental Health Act Review.

## 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's message on page four, 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 for the treatment and care of people with mental illness in Tasmania who are under the *Mental Health Act 2013*.

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.

Section 148 of the Act articulates independence of the Office of Chief Psychiatrist, not being subject to direction of the Minister or any other person.

Section 147 outlines the Power of Direct Intervention, which is the ability to intervene with regard to assessment, treatment and care of any patient.

The Chief Psychiatrist reports to the Deputy Secretary, Community, Mental Health and Wellbeing, DoH.

# CHAPTER 2: CHIEF PSYCHIATRIST- CIVIL DATA

This Chapter provides information on the Office of Chief Psychiatrist, and on administration of the Act.

## 2.1 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 2022 to 30 June 2023:

- 105 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.
- 20 people were approved as nurses for provisions of the Act within the Chief Psychiatrists' jurisdiction.
- No additional classes of people were approved as nurses for the purposes of relevant provisions of the Act.
- 103 ambulance officers were newly approved as mental health officers for the Act.
- 105 people other than ambulance officers were newly approved as mental health officers for the Act.

## 2.2 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 2022 to 30 June 2023:

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

## 2.3 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 2022 – 30 June 2023, 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.

## 2.4 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 2022 – 30 June 2023, no new Standing Orders were issued.

For the period 1 July 2022 – 30 June 2023, no new Clinical Guidelines 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. In the next reporting period, there will be a range of new Standing Orders and Clinical Guidelines to support Tranche 1 of the review implementation.

As part of the 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.

The Chief Psychiatrist is currently working on a guideline for Authorised Officers under the Act, a guideline for the use of the Act in those with dual disability, and a Standing Order for video surveillance in mental health units.

## 2.5 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 Act review, the Statement of Rights has been harmonised to a single statement for Involuntary and Forensic Patients.

## 2.6 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 2022 – 30 June 2023, the Chief Civil Psychiatrist delegated certain powers and functions under the Act to:

- Four people holding particular offices or positions.
- 30 people by name.

For the period 1 July 2022 – 30 June 2023, 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), the *Sentencing Act 1997* and the *Dangerous Criminals and High Risk Offenders Act 2021* to:

- Two people holding particular offices or positions.
- 18 people by name.

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, DoH. The controlling authority's power or delegation is set out in section 221 of the Act.

For the period 1 July 2022 – 30 June 2023, neither the Minister for Mental Health and Wellbeing nor the controlling authority delegated any of their powers and functions under the Act.

## 2.7 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 | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|---|---|
| North | 126 | 150 | 156 | 187 | 204 |
| North-West | 120 | 135 | 162 | 195 | 175 |
| South | 307 | 356 | 414 | 437 | 483 |
| Interstate | 5 | 6 | 7 | 7 | 1 |
| **Total** | **558** | **647** | **739** | **826** | **863** |
| % Children | 0.72% | 0.77% | 0.68% | 0.73% | 1.85% |
| % Female (all ages) | 43.37% | 42.1% | 43.44% | 44.19% | 43.80% |
| % Male (all ages) | 56.65% | 57.81% | 56.56% | 55.81% | 56.20% |

## 2.8 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.

The Chief Psychiatrist is committed to reducing the rate of restrictive interventions in Tasmania, and through the Statewide Seclusion and Restraint Oversight Committee, commits to a target of 6 per 10 000 bed days for 2023/2024. The Chief Psychiatrist is committed to having a rate below the national average.

For the period 1 July 2022 – 30 June 2023, 10 notifications of a child being secluded were received.

There were seven notifications received from the Launceston General Hospital (LGH), three notifications received from the North West Regional Hospital (NWRH) and nil notifications received from the Royal Hobart Hospital (RHH).

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 2018-19 to 2022-23***

| Area | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|---|---|
| LGH | 28 | 29 | 48 | 35 | 22 |
| NWRH | 19 | 18 | 54 | 10 | 28 |
| RHH | 81 | 105 | 112 | 158 | 152 |
| MRC | 7 | 3 | 1 | 1 | 12 |
| Roy Fagan Centre | 1 | 1 | 0 | 0 | 0 |
| **Total** | **136** | **156** | **215** | **204** | **214** |
| % Female (all ages) | 44.85% | 31.41% | 33.67% | 29.52% | 30.8% |
| % Male (all ages) | 58.39% | 68.59% | 66.33% | 70.48% | 69.2% |
| % Other (all Ages) | 0% | 0% | 0% | 0% | 0.00% |

For the period 1 July 2022 – 30 June 2023, 25 notifications of a child being restrained were received. There were 20 notifications received from the LGH, five notifications received from the NWRH, and nil notifications received from the RHH.

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 2018-19 to 2022-23***

| Area | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|---|---|
| **LGH** | **83** | **107** | **135** | **113** | **102** |
| Mechanical | 5 | 6 | 1 | 17 | 4 |
| Physical | 73 | 92 | 134 | 96 | 91 |
| Chemical | 5 | 9 | 0 | 0 | 7 |
| **NWRH** | **46** | **40** | **115** | **38** | **53** |
| Mechanical | 9 | 6 | 7 | 8 | 2 |
| Physical | 34 | 33 | 107 | 29 | 51 |
| Chemical | 3 | 1 | 1 | 1 | 0 |
| **RHH** | **85** | **84** | **126** | **143** | **135** |
| Mechanical | 1 | 1 | 2 | 3 | 1 |
| Physical | 78 | 78 | 122 | 135 | 120 |
| Chemical | 6 | 5 | 2 | 5 | 14 |
| **Millbrook Rise Centre** | **13** | **4** | **1** | **14** | **29** |
| Mechanical | 0 | 0 | 0 | 1 | 0 |
| Physical | 12 | 4 | 1 | 13 | 25 |
| Chemical | 0 | 0 | 0 | 0 | 4 |
| **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** | **227** | **235** | **377** | **308** | **319** |
| Mechanical | 15 | 13 | 10 | 28 | 7 |
| Physical | 197 | 207 | 364 | 273 | 287 |
| Chemical | 15 | 15 | 3 | 6 | 25 |
| **Mechanical Female** | 13.33% | 53.85% | 40.00% | 14.29% | 16.7% |
| **Mechanical Male** | 86.67% | 46.15% | 60.00% | 85.71% | 83.3% |
| **Physical Female** | 48.73% | 44.44% | 47.80% | 50.92% | 39.6% |
| **Physical Male** | 51.27% | 55.56% | 52.20% | 49.08% | 60.4% |
| **Chemical Female** | 40.00% | 20.00% | 33.33% | 0.00% | 56.0% |
| **Chemical Male** | 60.00% | 80.00% | 66.67% | 100.00% | 44.0% |

## STATEWIDE SECLUSION AND RESTRAINT OVERSIGHT COMMITTEE

The Statewide Seclusion and Restraint Oversight Committee meets on a quarterly basis and examines all incidents of seclusion and restrictive practices that have been reported to the Panel in the intervening period. The purpose of this Committee 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 Acting Chief Psychiatrist is Chair of the Statewide Seclusion and Restraint Oversight Committee.

Table 4 shows the number of seclusion events by year during the period of 2018-2023 and the breakdown by region.

***Table 4: Tasmanian Seclusion Events per 1 000 Bed Days by Inpatient Unit for the Period 2018 -19 to 2022-23***

| Unit | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|---|---|
| Northside | 5.7 | 4.9 | 9.2 | 6.0 | 3.3 |
| Spencer Clinic | 5.8 | 4.7 | 10.5 | 1.7 | 5.0 |
| RHH - Mental Health Inpatient Unit | 13.6 | 14.7 | 12 | 15.0 | 13.5 |
| * Millbrook Rise Centre | 1.6 | 0.3 | 0.1 | 0.1 | 1.5 |
| Wilfred Lopes Centre | 3.7 | 4.1 | 4.3 | 4.9 | 2.1 |
| **TOTAL (previously reported)** | **8.5** | **7.6** | **8.3** | **8.7** | **-** |
| ***TOTAL** | **6.4** | **6.5** | **7.1** | **6.3** | **5.8** |

** This year's report includes seclusion events per 1 000 bed days for Millbrook Rise Centre. Seclusion data per 1 000 bed days for Millbrook Rise Centre was not included in the previous financial years and as such the variation in total has been illustrated in this report.*

## 2.9 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 2022 – 30 June 2023, there were two children transferred twice between facilities.

Table 5 shows the number of involuntary patients transferred between facilities over the past five years by region. The shaded boxes illustrate data not obtained for these facilities.

***Table 5: Involuntary Patient Transfers between Facilities***

| Originating Hospital | Destination Hospital | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|---|---|---|
| LGH | RHH | 1 | 0 | 4 | 5 | 11 |
| LGH | NWRH | 7 | 13 | 41 | 23 | 17 |
| NWRH | RHH | 0 | 0 | 2 | 2 | 1 |
| NWRH | LGH | 6 | 7 | 4 | 19 | 6 |
| RHH | LGH | 4 | 0 | 5 | 5 | 9 |
| RHH | NWRH | 2 | 0 | 1 | 4 | 3 |
| RHH | Millbrook Rise | | | | | 9 |
| Millbrook Rise | RHH | | | | | 4 |
| LGH | Millbrook Rise | | | | | 1 |
| Millbrook Rise | LGH | | | | | Nil |
| NWRH | Millbrook Rise | | | | | 4 |
| Millbrook Rise | NWRH | | | | | Nil |
| RHH | Roy Fagan Centre | | | | | 7 |
| Roy Fagan Centre | RHH | | | | | 2 |
| LGH | Roy Fagan Centre | | | | | 1 |
| Roy Fagan Centre | LGH | | | | | Nil |
| NWRH | Roy Fagan Centre | | | | | 2 |
| Roy Fagan Centre | NWRH | | | | | Nil |
| Millbrook Rise | Roy Fagan Centre | | | | | 1 |
| Roy Fagan Centre | Millbrook Rise | | | | | 1 |
| **Total Transfers** | | **20** | **20** | **57** | **58** | **79** |

## 2.10 POWER OF DIRECT INTERVENTION

The Chief Civil Psychiatrist has the power under section 147 of the *Mental Health Act 2013* 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 2022 – 30 June 2023, 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.

## 2.11 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 2022 – 30 June 2023, the Chief Civil Psychiatrist did not correct any errors in Chief Civil Psychiatrist Approved Forms.

## 2.12 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.

## 2.13 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, and
- 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 | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|---|---|
| North | 133 | 125 | 121 | 111 | 105 |
| North-West | 186 | 196 | 202 | 201 | 196 |
| South | 219 | 197 | 241 | 238 | 186 |
| Interstate | 6 | 4 | 8 | 3 | 4 |
| **Total** | **544** | **522** | **572** | **553** | **491** |
| % Children | 7.17% | 7.17% | 8.22% | 4.70% | 6.92% |
| % Female (all ages) | 46.69% | 44.06% | 51.75% | 48.46% | 54.38% |
| %Male (all ages) | 53.31% | 55.94% | 48.25% | 51.54% | 45.62% |

As part of Tranche 1 of the Act review implementation, the term Protective Custody will be changed to 'Detaining for the purposes of assessment' which will be reflected in the next reporting period.

## 2.14 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 2022 – 30 June 2023, the Chief Civil Psychiatrist received 939 Assessment Order records made by medical practitioners. This was a decrease from the previous year in which 975 Assessment Order records were received.

## 2.15 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 | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|---|---|
| LGH | 3 | 4 | 1 | 7 | 12 |
| NWRH | 7 | 5 | 10 | 11 | 22 |
| RHH | 13 | 47 | 33 | 27 | 66 |
| **Total** | **23** | **56** | **44** | **45** | **100** |

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 | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|
| LGH | 51 | 57 | 58 |
| NWRH | 33 | 21 | 26 |
| RHH | 71 | 81 | 85 |
| Roy Fagan | 1 | 4 | 3 |
| Millbrook Rise | 1 | 2 | 1 |
| **Total** | **157** | **165** | **173** |

## 2.16 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 | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|---|---|
| North | 254 | 274 | 290 | 274 | 306 |
| North-West | 148 | 181 | 160 | 208 | 193 |
| South | 473 | 535 | 663 | 484 | 456 |
| Interstate | 10 | 9 | 10 | 11 | 6 |
| **Total** | **885** | **999** | **1123** | **977** | **961** |
| % Children | 1.81% | 2.50% | 1.96% | 1.02% | 2.08% |
| % Female (all ages) | 53.73% | 48.35% | 50.22% | 51.48% | 51.20% |
| % Male (all ages) | 46.27% | 51.65% | 49.69% | 48.52% | 48.80% |

# CHAPTER 3: CHIEF PSYCHIATRIST- FORENSIC 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.

## 3.1 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 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 five years.

***Table 10: Requests to Return to Prison/Youth Detention***

| | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|---|---|
| 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% |

## 3.2 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***

| | 2018-19 | 2019-20 | 2020-21 | 2021-222 | 2022-23 |
|---|---|---|---|---|---|
| Transfer to hospital | 32 | 148 | 91 | 44 | 39 |
| % Female (all ages) | 6.25% | 0.00% | 1.10% | 0.00% | 0.00% |
| % Male (all ages) | 93.75% | 100.00% | 98.90% | 100.00% | 100.00% |

## 3.3 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***

| | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|---|---|
| Leave of Absence | 4 | 17 | 6 | 34 | 106 |
| % 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% |

## 3.4 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 | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|---|---|
| Seclusion | 6 | 16 | 28 | 23 | 12 |
| % Female (all ages) | 0.00% | 6.25% | 3.57% | 4.35%% | 0.00% |
| % Male (all ages) | 100.00% | 93.75% | 96.43% | 95.65% | 100.00% |

Table 14 illustrates the number of restraint authority forms received by the Chief Forensic Psychiatrist for the year 2022-23 and the breakdown by sex.

***Table 14: Number of restraint authority forms received by the Chief Forensic Psychiatrist***

| Hospital | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|---|---|
| Restraint | | | | | 14 |
| % Female (all ages) | 0.00% | 6.25% | 3.57% | 4.35%% | 0.00% |
| % Male (all ages) | 100.00% | 93.75% | 96.43% | 95.65% | 100.00% |

No new means of restraint were approved by the Chief Forensic Psychiatrist during the 2022 –2023 Financial Year.

## 3.5 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 2022 – 30 June 2023, the Chief Forensic Psychiatrist did not cancel or suspend any individual's privileged visitor, privileged caller, or privileged correspondent status.

## 3.6 POWER OF DIRECT INTERVENTION

The Chief Forensic Psychiatrist has the power under section 147 of the *Mental Health Act 2013* 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 2022 – 30 June 2023, one application was made to the Chief Forensic Psychiatrist who did not exercise the power of direct intervention.

## 3.7 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 2022 – 30 June 2023, the Chief Forensic Psychiatrist did not correct any errors in Chief Forensic Psychiatrist approved forms.

## 3.8 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 2022 – 2023 Financial Year and in previous Financial Years is reported below in Table 14.

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

| | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|---|---|
| Reports Requested | 15 | 9 | 21 | 23 | 16 |

## 3.9 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 2022 – 30 June 2023, there were two authorisations of urgent circumstances treatment for a forensic patient.

## 3.10 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 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)***

| | 2018-19 | 2019-20 | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|---|---|
| Involuntary patient transfer to SMHU | 3 | 1 | 5 | 1 | 5 |
| % Female (all ages) | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| % Male (all ages) | 100.000% | 100.00% | 100.00% | 100.00% | 100.00% |

# CHAPTER 4: STATE CONTEXT

## 4.1 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 provided across Tasmania through the Tasmanian Health Service include:

- 24-hour acute inpatient services located at three public hospitals (the RHH Mental Health Inpatient Unit and Mental Health Short Stay Unit, the LGH Northside Clinic, and the NWRH 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 Emergency Response service
- The Peacock Centre providing short stay residential support, an Integration Hub, Safe Haven and Recovery College
- The Clozapine Clinic at the RHH
- 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 at 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, or choosing not to access)
- 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

## 5.1 MENTAL HEALTH ACT REVIEW IMPLEMENTATION PROJECT

The Tasmanian Minister for Mental Health and Wellbeing is required under section 229 of 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 Act 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 provides 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.

In 2020, the Minister for Mental Health and Wellbeing tabled the *Mental Health Act 2013: Review of the Act's Operation Outcomes Report*. The Act review continues to be implemented in a two-staged approach. Earlier this year, amendments to the Act were introduced and passed through both Houses of Parliament, with these due to come into effect on 25 September 2023.

Some of the main inclusions of the Amendment Bill are:

- The merging of the Chief Forensic Psychiatrist and Chief Civil Psychiatrist into the one title of Chief Psychiatrist.
- The strengthening of the provisions relating to children, including the expansion of the definition of parent to further protect the rights of children and an additional provision allowing consent for treatment to be withdrawn by a single parent, without agreement from both parents. This is particularly relevant in situations where parents are in conflict.
- Official Visitors can investigate complaints from children without parental or guardian consent, or a direct request access to records relating to a patient's assessment, treatment, and care.
- There will be a reduction in the maximum time of seclusion and restraint episodes with the initial episode being a maximum of three hours before a medical practitioner or approved nurse assesses the patient to see if the seclusion or restraint should continue or be terminated. If a continuation is required, this can be authorised for a maximum period of three hours. The maximum total for seclusion and restraint will be six hours before a new episode must be authorised by the Chief Psychiatrist or a delegate. Tasmania is currently the only state to have a maximum timeframe for seclusion and restraint.

- The name of Protective Custody will be changed to 'Detaining for the purposes of assessment' incorporating feedback from our Legislative Working Group that the term 'custody' was punitive and stigmatising. The provisions under section 17-21 of the Act will not change, just the title and the Approved Forms relating to this.
- There will be changes to personal leave requests, with requests for personal reasons able to be done verbally or in writing with someone who, in the opinion of the approved medical practitioner, has an interest in the patient's welfare. There will no longer be a requirement for patients to complete an application form for personal leave.

The Legislative Working Group and Forms Working Group continues to meet monthly to progress the Review Outcomes and the Steering Committee meets bi-monthly. Earlier in the year, two sub-committees were established to workshop the topics of capacity and the definition of serious harm within the meaning of the Act, and to provide advice on these key discussion topics back to the Working Groups and Steering Committee for decision. This work is now complete, and these sub-groups have consequently disbanded.

We were fortunate to have an extension to our Mental Health Act Review Implementation Project Officer funding until the end of December 2023 to lead the review implementation. Short-term funding will be allocated to recruit a dedicated training and education resource and ongoing funding for this role will be subject to a budget submission next financial year.

Planning is well underway for Tranche 2 of the implementation estimated for the later part of 2024 subject to Tranche 2 amendments passing through Parliament in May 2024. More details will be provided about Tranche 2 in the next reporting period.

## 5.2 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 2022 a roundtable discussion requested by the Tasmanian branch of the Australian Medical Association (AMA) was held with SMHS 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.

A key outcome from the first roundtable was that the Acting Chief Psychiatrist would develop guidelines to describe when the *Guardianship and Administration Act 1995* should be used, when the *Mental Health Act 2013* should be applied, and circumstances for using both pieces of legislation for people with a mental illness and intellectual disability (who are not able to consent to their mental health treatment). The guidelines are now in the final draft stages following updated advice from the Office of the Solicitor General. The Acting Chief Psychiatrist has been working with the Public Guardian, the SMHS Dual Disability Specialist, TASCAT and DoH Legal Services to finalise the latest

draft of the guideline. The second roundtable was in August 2023 to seek input from all members, including the Tasmanian branch of the AMA. Once endorsed, the guideline will be available for clinicians to assist them in navigating the two legislative frameworks.

## 5.3 VIDEO SURVEILLANCE IN MENTAL HEALTH FACILITIES

The Acting Chief Psychiatrist has been working closely with SMHS and DoH Legal Services to develop a Standing Order for managing the usage of surveillance cameras in mental health inpatient units and to ensure that patients' rights, dignity, and privacy are protected under the Act and the Personal Information Protection Act. There have been no guidelines in place for the management of surveillance in inpatient settings in Tasmania until now. The key message to clinicians is that the use of surveillance cameras should not be used to replace routine clinical observations, and that SMHS must take all reasonable steps to inform individuals and their support people about the use of surveillance devices, where the devices are located, and the purposes of their usage. Surveillance devices should not be used in private areas such as bathrooms, change rooms, and bedrooms. The development of this standing order will provide clinicians with greater clarity about their roles and responsibilities is recording, using, and storing patient data.

## 5.4 REPORTING OF CHEMICAL RESTRAINT

As part of the work of the Seclusion and Restraint Oversight Committee, it has been identified that the authorisation of chemical restraint appears less than would be expected according to the use of medications to manage acute behavioural disturbance.

Chemical restraint is a restrictive intervention and can cause distress for the patient, their support people, and staff and should be used as a last resort.

It is recognised that mental illness of itself can result in behavioural disturbance that needs treatment in the same way that other manifestations of the illness does.

In order to provide further clarity, the Acting Chief Psychiatrist will work with the Executive Director of Medical Services to amend both the Chief Psychiatrist Guideline and the SMHS Management of Acute Behavioural Disturbance Guideline for Adults. The aim of these amendments will be to clarify that if a person's behavioural disturbance is a manifestation of their underlying mental health condition, this would be regarded as part of treatment and not chemical restraint.

The Acting Chief Psychiatrist as the Chair of the Tasmanian Medicines Access and Advisory Psychotropic Steering Committee recognises that it is important to have oversight of the types and doses of medications used in chemical restraint and that the guideline is being followed, and will be looking at an audit process for this.

## 5.5 LIVED EXPERIENCE ADVISORY GROUP (LEAG)

The LEAG last met in April 2023 and is due to meet again in August 2023. The Acting Chief Psychiatrist would like to farewell a valued carer member of the group, Elida Meadows, who resigned from the group in June 2023 to move closer to her family and friends. Elida was a very passionate member of the group and will be missed, and I thank her for the contribution she has made to the group over her tenure. The Office of the Chief Psychiatrist will be undertaking an expression of interest process to replace Elida shortly. The LEAG will be fully utilised to provide lived experience input into Tranche 2 of the review implementation including reviewing approved forms, guidelines and standing orders.

## 5.6 PSYCHEDELIC ASSISTED THERAPIES IN TASMANIA (PSILOCYBIN and MDMA)

In February 2023, the Therapeutic Goods Administration (TGA) within the Australian Government Department of Health and Aged Care announced it will amend the Poisons Standard 4 to include in Schedule 8 (controlled substances) the prescribing of MDMA for post-traumatic stress disorder (PTSD) and psilocybin for treatment-resistant depression.

With this rescheduling, psychiatrists who are given approval by the TGA will be able to prescribe MDMA and psilocybin in certain circumstances limited to the treatment of PTSD and treatment-resistant depression. MDMA and psilocybin will remain a prohibited substance (Schedule 9) for any uses outside of these clinical purposes.

The TGA's decision to reschedule MDMA and psilocybin for these medical purposes is in response to Mind Medicine Australia's rescheduling application lodged in March 2022, backed by a significant number of Australians who provided submissions of support.

These changes will come into effect across Australia from 1 July 2023 with each State and Territory to develop their approach to support the roll out. In Tasmania, the approach to the medicinal utilisation of MDMA and psilocybin will be through a research basis, with applications for its use to be through the new Tasmanian Centre for Mental Health Service Innovation (Centre) led by Professor David Castle. The Centre is a partnership between the Department of Health and the University of Tasmania. This research approach is supported by the Tasmanian Medicines Access and Advisory Psychotropic Subcommittee of which the Acting Chief Psychiatrist and Chief Pharmacist are members. In considering this approach, the Subcommittee ensured there was consistency with the Royal Australian and New Zealand College of Psychiatrists which supports a research approach to build an evidence base to support the ongoing use of these therapies, and with reputable published guidelines.

The Acting Chief Psychiatrist and the Chief Pharmacist have jointly communicated to the relevant DoH clinicians about how this will be implemented in Tasmania and their training and ethical responsibilities in the use of psychedelic assisted therapies in Tasmania. Each application for the use of these therapies will also need to be considered by the Chief Psychiatrist in the implementation.

# 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.

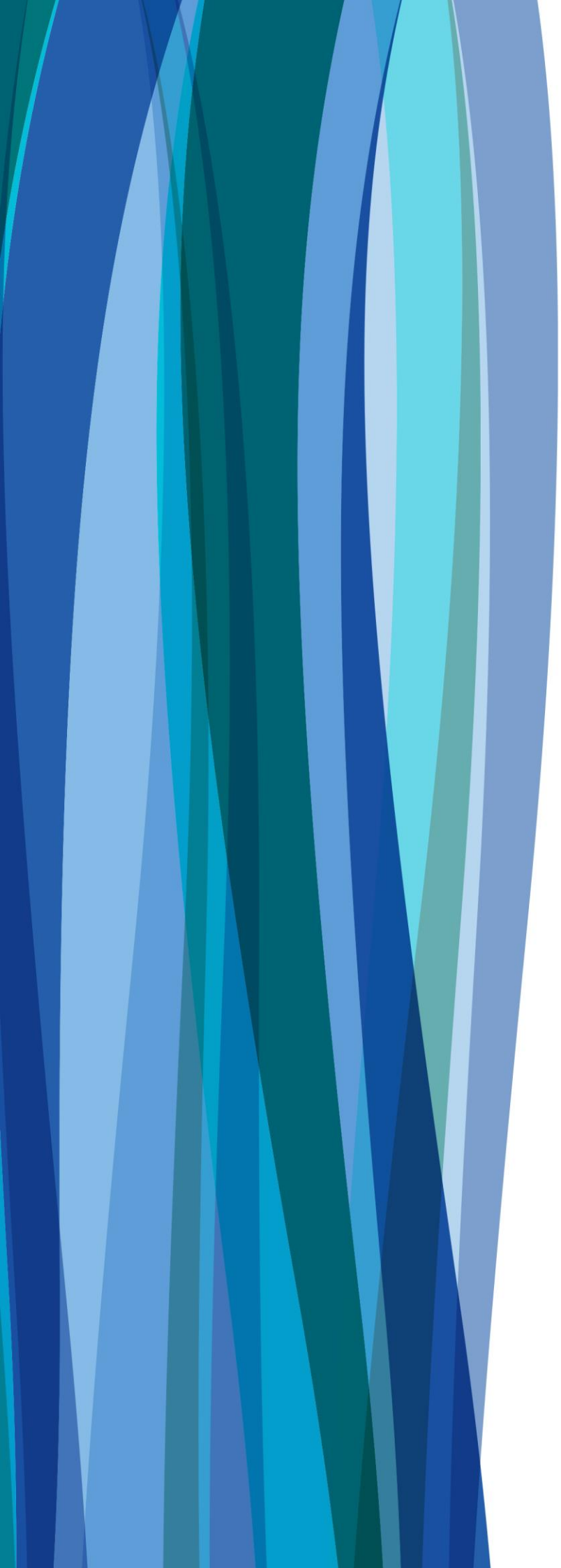
The Chief Forensic Psychiatrist's functions under the *Sentencing Act* are to provide advice to the Court under section 72 and to report to the Court under section 75.

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.



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