ANNUAL REPORT 2023-24

CHIEF PSYCHIATRIST

Office of the Chief Psychiatrist
Clinical Quality, Regulation and Accreditation
Department of **Health**

Tasmanian Government

Contents

Chief Psychiatrist Message

I am pleased to present the Chief Psychiatrist's Annual Report for 2023–24, in accordance with section 150 of the *Mental Health Act 2013* (Tas) (the Act).

I begin by acknowledging the original custodians of Lutruwita (Tasmania), the Palawa people, and I pay my respects to elders past, present, and emerging. I also reaffirm my strong commitment towards Closing the Gap.

We are indebted to generations before us who made Tasmania their home. The life and environment that we enjoy today in Tasmania is an acknowledgement of their immense contribution. The value we place on respecting the diversity, wellbeing and autonomy of every Tasmanian is also reflected in the Act. An essential tenant of the Act is respecting the rights of the individual to appropriate care and treatment and interfering with those rights only to protect their health and safety.

The processes that are followed in the Act are informed by invaluable knowledge and wisdom of mental health experts and people with lived experience of mental health, their families and friends. We remain committed to ensuring that their participation and advice continue to help improve mental health outcomes for all Tasmanians.

During the 2023-24 reporting period, Associate Professor Anthony Cidoni acted as Tasmania's Acting Chief Psychiatrist until January 2024, when I was entrusted with this responsibility.

I would particularly like to acknowledge the continuing support and guidance of the Tasmanian Civil and Administrative Tribunal (TASCAT – Mental Health Stream), Mental Health Lived Experience Tasmania (MHLET), Mental Health Families and Friends (MHFF), Mental Health Council Tasmania and Tasmania Legal Aid.

I am immensely grateful to the Office of the Chief Psychiatrist (OCP) for their expertise and commitment to enable me to fulfil my statutory responsibilities. In 2023-24, the OCP, with the help and support of our stakeholders, has project-managed the implementation of recommendations from the Mental Health Act Review which will enable further refinements to the Act. The OCP also prepares useful best practice guidance and advice, oversees seclusion and restraints and now delivers regular education and training on various aspects of the Act.

I am committed to working with all our stakeholders to strengthen Tasmania's mental health system and enable us to provide the best possible and least restrictive treatment.

Professor Dinesh Arya
Chief Psychiatrist, Department of Health
30 September 2024

Chapter 1: Background

The Mental Health Act 2013 (the Act) provides a legislative framework for the assessment and treatment of people with mental illnesses. It outlines when and how treatment can be given to voluntary, involuntary, and forensic patients while protecting their rights.

The Act focuses on promoting individual autonomy. It prescribes a clear process for making assessment and treatment decisions, including for those who lack decision-making capacity to make decisions that are in their best interest due to their mental illness. The Act requires that treatment be provided in the least restrictive way possible, balancing clinical needs and public safety while encouraging voluntary treatment whenever possible.

A review of the Act was completed in 2020. This was followed by the development of a Legislative Working Group and Steering Committee, including representatives from across the sector and consumers, that oversaw the development of recommendations to refine the Mental Health Act processes. The first tranche of amendments to the Act took effect on 25 September 2023. In 2023-24, work continued to identify opportunities for further refinement of the Act.

Role of the Chief Psychiatrist

Under the Mental Health Act 2013 (the Act), the Chief Psychiatrist is a statutory appointment made by the Governor.

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. Section 147 grants the Chief Psychiatrist the power of direct intervention in the assessment, treatment, and care of both voluntary and involuntary patients with mental illness, particularly in cases involving seclusion, restraint, leave, patient information, and treatment. Section 148 of the Mental Health Act 2013 outlines that the Chief Psychiatrist operates independently.

Functions of the Chief Psychiatrist

The Chief Psychiatrist has the following functions:

- to promote the care and treatment for persons who have a mental illness in line with the Act.
- to advise the Minister on the care, treatment, control, and protection of persons with mental illness and the operation of mental health services.
- to make and oversee standards, guidelines, and clinical protocols for mental health professionals, facilities, and anyone else exercising functions under the Act.
- to monitor the care and treatment in mental health facilities to ensure compliance with the Act.
- any other function given to the Chief Psychiatrist under the Act.

Powers Under Other Acts

The Chief Psychiatrist holds various powers and functions under the following acts:

- *Criminal Justice (Mental Impairment) Act 1999*
- *Sentencing Act 1997*
- *Criminal Code Act 1924*
- *Corrections Act 1997*
- *Youth Justice Act 1997*
- *Dangerous Criminals and High Risk Offenders Act 2021*

These powers include reporting to the Court, supervising individuals, and authorising treatment and admissions to secure mental health units across various legal contexts.

Chapter 2: Mental Health Act Processes

Under the Mental Health Act 2013 (the Act), the Chief Psychiatrist oversees key processes, including delegations, approvals, and the management of statutory functions. These processes ensure compliance and also support clinicians in delivering care that protects patient rights and promotes least restrictive practices.

2.1 Approvals and Delegations

The Act provides for approved medical practitioners, approved nurses, and mental health officers in Sections 138 (Approved medical practitioners and nurses) and 139 (Mental health officers) of the Act to undertake specific functions under the Act. The Chief Psychiatrist may also delegate his powers or functions under section 149 (Delegation) of the Act. The power of delegation does not extend to the power to issue, vary, or revoke Clinical Guidelines and Standing Orders or powers relating to special psychiatric treatment.

Approved Personnel

For the period 1 July 2023 – 30 June 2024:

- 183 medical practitioners were newly approved (or their approval renewed) as approved medical practitioners.
- 27 nurses were approved as approved nurses. In addition, nurses with postgraduate mental health or psychiatric nursing qualifications were given class approval as approved nurses.
- 97 ambulance officers and 249 mental health clinicians other than ambulance officers were newly approved (or their approval renewed) as mental health officers.

Delegations

The Chief Psychiatrist delegated specific powers and functions under the non-forensic provisions of the *Mental Health Act 2013*, including authorisation of seclusion, restraint and transfer between approved hospitals. For the period 1 July 2023 to 30 June 2024, these delegations were granted to six people holding particular offices or positions and 33 people by name.

Under the forensic provisions of the *Mental Health Act 2013,* as well as other Acts listed in **Powers Under Other Acts** section on page 5, the Chief Psychiatrist delegated powers includes authorisation of seclusion and restraint, transfer between approved facilities, visiting and telephone rights, searches and seizure, reporting to the court, supervising individuals, and authorisation of treatment and admissions to secure mental health unit. For the period 1 July 2023 to 30 June 2024, these delegations were granted to two people holding particular offices or positions and 25 people by name.

2.2 Approved Information and Forms

The Chief Psychiatrist is responsible for approving forms, standing orders, and clinical guidelines to ensure compliance with the Mental Health Act. These documents guide clinicians, consumers, and their families, helping them navigate the Act effectively. They are available on the Chief Psychiatrist's website.

Approved Forms

The Chief Psychiatrist has the power to approve forms for use under provisions of the Act or under provisions of other Acts in respect of which he may have responsibilities.

In the period 1 July 2023 – 30 June 2024, 17 forms were revised and approved for use.

These forms were released on 25 September 2023 to coincide with the commencement of legislative changes to the Mental Health Act 2013, resulting in an overall reduction of forms.

Appendix 1 contains the complete list of currently approved forms.

Standing Orders and Clinical Guidelines

Clinical Guidelines and Standing Orders provide practical instructions on how to apply the provisions of the Act or other Acts in clinical or forensic settings. Issued by Chief Psychiatrists, these guidelines assist medical professionals, nurses, and others in carrying out their duties related to assessment and treatment under the Act. The authority to issue such guidelines is outlined in section 151 of the Act.

Four new standing orders and four new clinical guidelines were issued for the period 1 July 2023 – 30 June 2024.

Appendix 2 contains a list of Standing Orders and Clinical Guidelines as on 30 June 2024.

The Chief Psychiatrist is reviewing these documents and plans to release a new suite of Standing Orders and Advisory Notes in the next reporting period.

Statement of Rights

The Chief Psychiatrist is responsible 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 and in place as on 30 June 2024 were 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.*

2.3 Detaining for the Purposes of Assessment

Sections 17 to 21 of the Act give the ability for a mental health officer or police officer to detain a person if they believe:

- the person has a mental illness, and
- the person should be assessed against the assessment criteria, and
- the person's safety or the safety of other persons is likely to be at risk if the person is not so detained.

Table 1 below shows the number of detentions for assessment by region over five years, including the percentage of children and gender breakdown.

Table 1: Number of People Detained for the Purposes of Assessment by Region

Area	2019 20	2020 21	2021 22	2022 23	2023 24*
North	125	121	111	105	79
North-West	196	202	201	196	218
South	197	241	238	186	67
People from Interstate	4	8	3	4	6
Total	**522**	**572**	**553**	**491**	**370**
% Children	7%	8%	5%	7%	12%
% Female (all ages)	44%	52%	48%	54%	49%
% Male (all ages)	56%	48%	52%	46%	51%

Note: *The sharp decline noted in 2023-24 is unexpected and difficult to explain, casting doubt on the accuracy of the data. We suspect a potential form submission or reporting error. This is being investigated further.

2.4 Assessment Orders

A medical practitioner can make an Assessment Order if they have examined the person within the previous 24 hours and believe the person meets the assessment criteria under the Act. The medical practitioner must also be satisfied that informed consent for the assessment was either not possible or trying to take it was inappropriate.

Sections 22-35 of the Act provide key details for assessment orders, and section 25 explains assessment criteria, which include:

- The person has, or appears to have, a mental illness that requires or is likely to require treatment for:
    - the person's health or safety OR the safety of other persons AND
    - the person cannot be properly assessed with regard to the mental illness or the making of a treatment order except under the authority of the assessment order AND
    - the person does not have decision-making capacity.

Table 2: Number of Assessment Orders by Region

Area	2019 20	2020 21	2021 22	2022 23	2023 24
North		305	284	317	280
North-West		147	206	199	179
South		640	475	451	408
People from Interstate		9	12	12*	14
Total	**988**	**1,101**	**977**	**979**	**881**
% Children		2%	1%	2%	3%
% Female (all ages)		50%	52%	51%	47%
% Male (all ages)		50%	48%	49%	53%

Note: Previous data from 2020-2021 to 2022-2023 were revised due to system improvements.

* 1 from a person overseas. Data from 2019-2020 is not comparable due to unrecoverable file loss.

Trend Summary: The number of assessment orders has declined from 1,101 in 2020-21 to 881 in 2023-24. Children account for 1-3% of assessment orders, with a slight shift in gender distribution toward males (53% in 2023-24).

2.5 Treatment Orders

A treatment order (TO) authorises involuntary treatment of a person as outlined in their treatment plan, which may occur in a hospital, the community, or a combination of both. Approved medical practitioners (AMP) can apply to the Tribunal for making a treatment order, which may follow an assessment order but can also be applied for independently if treatment criteria are met. Section 40 of the Act sets out the treatment criteria, which include:

- the person has a mental illness; AND
- without treatment, the mental illness will, or is likely to, seriously harm –
    - the person's health or safety OR the safety of other persons; AND
    - the treatment will be appropriate and effective; AND
    - the treatment cannot be adequately given except under a treatment order; AND
    - the person does not have decision-making capacity.

In urgent cases, a single Tribunal member may issue an interim treatment order (ITO) upon the application of an AMP, where a delay in treatment could seriously harm the person or others (Section 38).

Table 3: Number of authorised treatment orders and outcomes

	2019 20	2020 21	2021 22	2022 23	2023 24
ITOs made by Tribunal	509	549		529	639
TOs made by the Tribunal	384	395		457	463
TO Renewals	313	311	338	358	394
TO dismissed by Tribunal after a hearing	1	2		21	10

Note: Data gaps before 2021-22 are due to unavailability of accurate data.

Trend Summary: Over the five-year reporting period, TO applications increased from 585 to 671 and renewals from 313 to 394. Tribunal-approved TOs reached 463, while ITOs rose from 509 to 639. Dismissals peaked at 21 in 2022-23 and declined to 10 in 2023-24.

Failures to Comply with Treatment Orders

If a person receiving involuntary treatment under a Treatment Order fails to comply with a Treatment Order, under section 47 of the Act, a treating medical practitioner may require the person to be admitted and, if necessary, require detention as an involuntary patient in an approved hospital.

Table 4 provides a breakdown of failure to comply with treatment orders made because of non-compliance with Treatment Orders by the facility over the past five years, along with actions taken under section 47. Facility acronyms are as follows: Launceston General Hospital (LGH), North West Regional Hospital (NWRH), and Royal Hobart Hospital (RHH).

Table 4: Failures to Comply with TOs – Action Taken under Section 47 by Facility

Facility	2019 20	2020 21	2021 22	2022 23	2023 24
LGH	4	1	7	9	12
NWRH	5	10	11	7	7
RHH	47	33	27	36	36
Roy Fagan Centre				3	2
Total	**56**	**44**	**45**	**55**	**56**

Note: Previous data for 2022-2023 was amended due to a reporting revision.

Admissions to Prevent Possible Harm - Action Taken

A patient's treating medical practitioner may also seek to have a patient receiving involuntary treatment under a Treatment Order who has remained compliant with a Treatment Order but 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 5 below shows the number of admissions to prevent potential harm by facility and action taken under section 47A of the Act.

Table 5: Admissions to Prevent Possible Harm - Action Taken under Section 47A of the Act by Facility

Facility	2020 21	2021 22	2022 23	2023 24
LGH	51	57	58	35
Millbrook Rise	1	2	1	3
NWRH	33	21	26	24
RHH	71	81	85	60
Roy Fagan	1	4	3	4
Total	**157**	**165**	**173**	**126**

Failures to Comply and Admissions to Prevent Harm

In 2023-24, nine individuals were BOTH non-compliant with their Treatment Orders AND required admission to prevent harm (1 for NWRH and 8 for RHH). Data before 2023-24 was not collected due to a form amendment allowing both parts to be selected.

2.6 Urgent Circumstances Treatment

Urgent Circumstances Treatment is given without informed consent or Tribunal approval when an approved medical practitioner deems it urgently needed in the patient's best interests. Section 55 of the Act outlines when this can be given to involuntary patients.

Table 6 shows the number of people authorised for Urgent Circumstances Treatment by region over the past five years, including the proportion of children compared to the total number and a breakdown by gender.

Table 6: Authorisations of Urgent Circumstances Treatment by Region

Area	2019 20	2020 21	2021 22	2022 23	2023 24
North	274	290	274	306	238
North-West	181	160	208	193	171
South	535	663	484	456	342
Interstate	9	10	11	6	11
Total	**999**	**1,123**	**977**	**961**	**762**
% Children	3%	2%	1%	2%	4%
% Female (all ages)	48%	50%	51%	51%	47%
% Male (all ages)	52%	50%	49%	49%	53%

Trend Summary: Urgent Circumstances Treatment authorisations decreased from 1,123 in 2020-21 to 762 in 2023-24, with the South seeing the most significant decline. Children accounted for 1-4% of total authorisations over the period, peaking at 4% in 2023-24. Males made up 53% of cases.

2.7 Seclusion and Restraint

Involuntary patients may be placed in seclusion or under restraint 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.

Section 56 allows seclusion only when necessary for the patient's safety, the safety of others, or for treatment purposes, and requires regular reassessment after 3 hours.

Section 57 permits restraint if it is needed to prevent harm to the patient or others, with the type and duration of restraint being carefully monitored and reassessed within 3-hour intervals.

Seclusion and restraint are restrictive interventions. These interventions are used as a last resort option 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 Psychiatrist, and the Tribunal. A copy of the record is also required to be placed on the patient's clinical record. Each facility has a Restrictive Intervention Panel that provides broad oversight of the utilisation of seclusion and restraint and leadership towards elimination of the utilisation of seclusion and restraint across Tasmania.

A Statewide Seclusion and Restraint Oversight Committee oversees State-wide seclusion and restraints. This Committee meets quarterly and examines seclusion and restrictive practices that have been reported to the Restrictive Intervention Panels in the intervening period. The purpose of this Committee is to identify structural and system trends with a view to implementing suitable remedies to reduce these practices.

The Tasmanian Health Service *Plan* also committed to a target of less than six seclusions per 1,000 bed days for 2023-24. The most recent published National average for seclusion is 6 for 2022-23[1]. In 2023-24 Tasmania exceeded the target and had 7.8 seclusions per 1,000 bed days, an increase from 5.8 in 2022-23. The National average in 2022-23 for seclusion in the Forensic setting was nine. Tasmania's rate was 1.6 in 2023-24.

Tasmanian Seclusion Events Data

Table 7: Tas Seclusion Rates per 1,000 Bed Days by Location (2019-20 to 2023-24)

Unit	2019 20	2020 21	2021 22	2022 23	2023 24
LGH – Northside	4.9	9.2	6.8	3.3	2.3
NWRH – Spencer Clinic	4.7	10.5	2.1	5.0	9.5
RHH – MH Inpatient Unit	14.7	12.0	15.0	13.5	16.0
RHH – MH Short Stay Unit	-	-	0.0	0.0	7.4
Millbrook Rise Centre	0.5	0.2	0.2	2.2	2.6
Wilfred Lopes (Forensic)	4.1	4.3	4.7	2.1	1.6
Total	**7.2**	**7.9**	**6.9**	**5.8**	**7.8**

From 1 July 2023 to 30 June 2024, 26 child seclusion notifications were received: one from LGH, one from RHH, and 24 from NWRH. One consumer is responsible for the high total for NWRH. Tables 7 and 9 show seclusion data by location and gender.

Table 8: Occasions of Seclusion Events by Location from 2019-20 to 2023-24

Hospital	2019 20	2020 21	2021 22	2022 23	2023 24
LGH – Northside	31	55	45	22	15
NWRH – Spencer	25	59	12	28	57
RHH – Inpatient Units	166	138	169	152	196
Millbrook Rise Centre	3	1	1	12	13
Wilfred Lopes Centre	20	28	27	12	10
Total	**245**	**281**	**254**	**226**	**291**
% Female (all ages)	33%	25%	23%	29%	23%
% Male (all ages)	67%	75%	77%	71%	77%

[1] https://www.aihw.gov.au/mental-health/topic-areas/seclusion-and-restraint

Tasmanian Restraint Events Data

Table 9: Restraint Events by Location and Type from 2019-20 to 2023-24

Location	2019 20	2020 21	2021 22	2022 23	2023 24
LGH – Northside					
Mechanical	-	-	-	1	1
Physical	74	123	76	92	89
Chemical	-	-	-	-	1
LGH – Northside Total	**74**	**123**	**76**	**93**	**91**
NWRH – Spencer					
Mechanical	-	-	1	1	2
Physical	19	113	27	51	95
Chemical	-	-	-	-	2
NWRH – Spencer Total	**19**	**113**	**28**	**52**	**99**
RHH – Inpatient Units					
Mechanical	-	-	-	-	2
Physical	101	76	150	109	188
Chemical	-	2	-	14	6
RHH – Inpatient Units Total	**101**	**78**	**150**	**123**	**196**
Millbrook Rise Centre					
Mechanical	-	1	-	-	-
Physical	4	2	6	24	11
Chemical	-	-	-	4	-
Millbrook Rise Centre Total	**4**	**3**	**6**	**28**	**11**
Wilfred Lopes Centre					
Mechanical	1	-	-	2	7
Physical	21	18	20	12	7
Chemical	-	2	-	-	-
Wilfred Lopes Centre Total	**22**	**20**	**20**	**14**	**14**
State					
Mechanical	1	1	1	3	12
Physical	219	332	279	288	390
Chemical	0	4	0	19	9
State Total	**220**	**337**	**280**	**310**	**411**
Mechanical Female	53%	40%	20%	22%	17%
Mechanical Male	47%	60%	80%	78%	83%
Physical Female	44%	45%	52%	36%	34%
Physical Male	56%	55%	48%	64%	66%
Chemical Female	20%	33%	0%	56%	33%
Chemical Male	80%	66%	100%	44%	66%

Table 9 above shows the occasions of restraint events by hospital, type of restraint used, and gender breakdown.

From 1 July 2023 to 30 June 2024, 25 child restraint notifications were received: four from LGH, two from RHH, and 19 from NWRH. One consumer explains the NWRH high total.

2.8 Transfer of Involuntary Patients Between Hospitals

Under section 59 of the Act, the Chief Psychiatrist or delegate can transfer an involuntary patient between approved hospitals if necessary for their health or safety or the safety of others. This can occur if the required treatment or care is not available at the current hospital or if the transfer is needed to manage risks associated with the patient's behaviour or condition.

Table 10 shows involuntary patient transfers by region over the past five years, with shaded boxes for unavailable data.

Table 10: Involuntary Patient Transfers between Facilities from 2019-20 to 2023-24

Originating Hospital	Destination Hospital	2019 20	2020 21	2021 22	2022 23	2023 24
LGH	Millbrook Rise				1	3
LGH	NWRH	13	41	23	17	14
LGH	RHH	Nil	4	5	11	4
LGH	Roy Fagan Centre				1	Nil
Millbrook Rise	LGH				Nil	1
Millbrook Rise	NWRH				Nil	1
Millbrook Rise	RHH				4	9
Millbrook Rise	Roy Fagan Centre				1	Nil
NWRH	LGH	7	4	19	6	10
NWRH	Millbrook Rise				4	4
NWRH	RHH	Nil	2	2	1	Nil
NWRH	Roy Fagan Centre				2	1
RHH	LGH	Nil	5	5	9	8
RHH	Millbrook Rise				9	20
RHH	NWRH	Nil	1	4	3	Nil
RHH	Roy Fagan Centre				7	12
Roy Fagan Centre	LGH				Nil	Nil
Roy Fagan Centre	Millbrook Rise				1	Nil
Roy Fagan Centre	NWRH				Nil	Nil
Roy Fagan Centre	RHH				2	3
Total Transfers		**20**	**20**	**57**	**58**	**92**

One child was transferred once between facilities from 1 July 2023 to 30 June 2024.

CHAPTER 3: Forensic Mental Health

The Chief Psychiatrist holds delegated functions under the Mental Health Act and other Acts, with the power to perform these functions as needed. This includes overseeing the leave of forensic mental health patients, managing transfers, authorising seclusion or restraint, correcting non-material form errors, and intervening in assessing, treating, and caring for forensic patients when necessary.

Tasmania has one secure mental health facility, the Wilfred Lopes Centre (WLC), with a capacity for 30 inpatient beds. Twenty are currently funded by the Department of Health, eight in the high dependency unit and 12 in the extended care unit.

For 2023-24, a total of 35 patients were admitted to WLC. Of these, 18 were prisoners under section 36a (removal of a prisoner from a prison to a Secure Mental Health Unit), five were admitted under section 31 (apprehended subject to order), two under section 63 (civil cases), and ten under Restriction Orders (RO) under the *Corrections Act 1997*. A restriction order limits a person's movement or activities for safety reasons, ensuring they stay in a secure facility while receiving medical or psychiatric care to protect them and the public.

Regarding gender, 31 of the admitted patients were male, while four were female. All females were admitted as prisoners under section 36a.

Table 11: Length of Stay (LOS) in days by Age Group and Restriction Orders, 2023-24

Ages	Subj. to RO	Non RO	Average LOS All	Avg LOS Excl. RO
18-24	0	4	331.5	331.5
25-34	1	9	629.9	99.1
35-44	4	5	1,542.8	179.8
45-54	3	5	788.6	80.6
55-64	2	2	1,404	200.5
Totals	**10**	**25**	**955.3**	**156.8**

3.1 Forensic Treatment Orders

In 2023-24, 15 forensic patients were issued with Treatment Orders (TOs), and three received Authorisations of Treatment (AoT) at the Wilfred Lopes Centre (WLC).

AoTs are applied when a patient is admitted to WLC without an existing TO, an AoT reverts to TOs upon discharge, valid for six months. Unlike a TO, an AoT does not require a current Treatment Plan. The Tribunal oversees and reviews both AoTs and TOs at 60-day and 180-day intervals.

Table 12: Treatment Orders for 2023-24 Forensic Admissions

Category	2023 2024
Subject to Treatment Order prior to Admission	10
Authorisation of Treatment applied after Admission	7
Not subject to any order for treatment	1

3.2 Forensic Patient Transfers

Return to Prison: Under section 70 of the Act, forensic patients may request (subject to review by the Tribunal) a return to custody. In 2023-24, no such requests were made (as has been the case for the last five years).

Transfer to Hospitals: Under section 73 of the Act, the Chief Psychiatrist may direct the transfer of forensic patients to an institution, hospital, or health service for specialist care.

From July 2023 to June 2024, 118 forensic patients were transferred, with 87% going to the Royal Hobart Hospital. Other transfers were for allied health, dental, or outpatient appointments. All transfers were male.

Table 13: Forensic Patient transfers to Hospital etc

	2019 20	2020 21	2021 222	2022 23	2023 24
Transfer to hospital	148	91	44	39	118

3.3 Leave of Absence

The Chief Psychiatrist or delegate may apply to the Tribunal to extend, vary, or cancel leave of absence for forensic patients under restriction orders (sections 78 and 79) or for patients not under restriction orders (sections 82 and 83).

In 2023-24, 171 leave of absence approvals were granted to forensic patients not under restriction orders, with 11 varied and one cancelled. This marks a significant increase from previous years, with all approved leaves granted to male patients, as seen in Table 14.

Table 14: Leave of Absence Granted to Forensic Patients who are not subject to Restriction Orders

	2019 20	2020 21	2021 22	2022 23	2023 24
Leave of Absence	17	6	34	106	171

3.4 Seclusion and Restraint

Forensic patients may be placed in seclusion or under restraint only under limited circumstances, as per sections 94 and 95 of the Act. No new means of restraint were approved by the Chief Psychiatrist during 2023-24.

Seclusion: The number of seclusion authority forms, each documenting an episode of seclusion and any continuations, has fluctuated over the past five years. In 2023-24, 15 forms were submitted, with 13% involving female patients, an increase from previous years when male patients dominated.

Table 15: Number of seclusion authority forms received by the Chief Psychiatrist

Hospital	2019 20	2020 21	2021 22	2022 23	2023 24
Seclusion	16	28	23	12	15
% Female (all ages)	6%	4%	4%	0%	13%
% Male (all ages)	94%	96%	96%	100%	87%

Restraint: In 2023-24, 19 restraint authority forms were submitted, each recording an episode of restraint and any continuations. Of these, 16% involved female patients. The breakdown includes ten cases of mechanical restraint, eight cases of physical restraint, and one case involving both mechanical and chemical restraint.

Table 16: Number of restraint authority forms received by the Chief Psychiatrist

Hospital	2019 20	2020 21	2021 22	2022 23	2023 24
Restraint				14	19
% Female (all ages)	6%	4%	4%	0%	16%
% Male (all ages)	94%	96%	96%	100%	84%

3.5 Functions and Powers – Forensic

Section 109 of the Act authorises certain individuals to exercise powers related to forensic patients, including transporting them between facilities, applying limited force, managing visitors, and overseeing their communications.

Cancellation or Suspension of Privileged Visitor, Caller, or Correspondent Status: Under sections 97-107, forensic patients are entitled to visits, calls, and correspondence. Consistent with previous years, no cancellations of entitlements occurred in 2023-24.

Power of Direct Intervention: The Chief Psychiatrist can intervene in forensic patient care for seclusion, restraint, and leave, though no interventions were made in 2023-24.

Functions and Powers Under Other Acts: The Chief Psychiatrist also performs functions under the *Criminal Justice (Mental Impairment) Act 1999, Corrections Act 1997, Youth Justice Act*, *Criminal Code Act*, *Justices Act, Sentencing Act 1997,* and the *Dangerous Criminals and High Risk Offenders Act 2021*, providing reports to Courts and other bodies.

Seven reports were requested in 2023-24, including two high-risk offender reports. Most reports are prepared in practice by delegates of the Chief Psychiatrist.

Table 17: Number of reports requested from the Chief Psychiatrist

	2019 20	2020 21	2021 22	2022 23	2023 24
Reports Requested	9	21	23	16	7

3.6 Urgent Circumstances Treatment – Forensic

Urgent Circumstances Treatment is administered without informed consent or Tribunal approval when an approved medical practitioner deems it necessary for the patient's wellbeing.

Four authorisations of Urgent Circumstances Treatment for a forensic patient were issued from 1 July 2023 – 30 June 2024.

3.7 Admission of Involuntary Patients to SMHU

Under section 63 of the Act, involuntary patients (non-forensic) may be admitted to a secure mental health unit (SMHU) if they pose a serious danger to themselves or others and cannot be safely detained elsewhere.

Admissions of involuntary patients to SMHUs have remained low over the past five years, with three recorded in 2023-24, down from a peak of five in 2020-21 and 2022-23, all involving male patients.

Table 18: Admissions of Involuntary Patients to Secure Mental Health Units (SMHU)

	2019 20	2020 21	2021 22	2022 23	2023 24
Involuntary patient transfer to SMHU	1	5	1	5	3
% Male (all ages)	100%	100%	100%	100%	100%

Chapter 4: Update on the Mental Health Act Review Implementation

In 2020, the Tasmanian Minister for Mental Health and Wellbeing commissioned a review of the Mental Health Act. The review produced 29 recommendations, all of which were accepted. These recommendations covered changes to legislation, education, training, and resources to be implemented across two stages.

Tranche 1 Amendments

The first stage (Tranche 1) was completed in early 2023, with the Mental Health Act Amendment Bill 2022 coming into effect on 25 September 2023. This stage also included updates to approved forms, Standing Orders, and Clinical Guidelines.

Key legislative changes in Tranche 1 included:

- Establishment of a unified role for the Chief Psychiatrist (previously split as Civil Chief Psychiatrist and Forensic Chief Psychiatrist).
- Strengthening provisions relating to children with the expansion of the definition of a parent and introduction of a provision allowing consent for treatment of a child to be withdrawn by a single parent.
- Simplifying the process for patients requesting personal leave from an approved hospital.
- Improving safeguards and oversight allowing Official Visitors to investigate complaints relating to children without a parental or guardian consent, or a direct request from the child.
- Reduction to the maximum timeframes of seclusion and restraint and further restrictions on who may authorise consecutive episodes.
- Updating terminology from ‘Protective Custody’ to ‘Detaining for the Purposes of Assessment’ to avoid stigmatising language.

Tranche 2 Amendments

In 2023-24 discussions continued to consider Tranche 2 amendments and involved extensive consultation with key stakeholders, including lived experience groups and legal experts. The project steering committee, legislative working group, and forms and documents working group have completed their reviews, and the proposed amendments are being finalised.

The second stage (Tranche 2 amendments) involves more complex changes, such as:

- removing barriers to timely treatment
- improving safety for consumers and staff
- eliminating stigmatising language
- streamlining the Act to make it easier to understand and apply.

Education and training

The Office of the Chief Psychiatrist (OCP) now provides monthly targeted education and training to clinicians. Additional education and training sessions are organised, as required.

Appendix 1: Approved Forms

Current forms approved by the Chief Psychiatrist amendments to the Mental Health Act 2013 in 2023, and a new suite of forms were released by the Chief Psychiatrist on 25 September 2023.

The following forms were in place as of 30 June 2024:

General (non-Forensic) Mental Health Services

- (C04) - Detaining for Assessment
- (C06) - Assessment Order, Affirmation or Discharge
- (C07) - Treatment Plan
- (C08) - Urgent Circumstances Treatment (Involuntary)
- (C09) - Seclusion (Involuntary)
- (C10) - Restraint (Involuntary)
- (C12) - Patient Leave (Involuntary)
- (C13) - Involuntary Patient Transfer Between Approved Hospitals
- (C19) - Involuntary Patient Admission to Secure Mental Health Unit
- (C22) - Readmission of Patient on treatment Order
- (C24) - Escort

Secure Mental Health Unit, Wilfred Lopes Centre

- (F08) - Urgent Circumstances Treatment (Forensic)
- (F09) - Seclusion (Forensic)
- (F10) - Restraint (Forensic)
- (F12) - Leave (Forensic)
- (F16) Search and Seizure (SMHU)
- (F17) - Forensic Patient Transfer to Hospital
- (F20) - Patient Return to Prison/Youth Detention.

Appendix 2: Standing Orders and Clinical Guidelines

Standing Orders

The following Standing Orders issued by the Chief Psychiatrist were in place as of 30 June 2024:

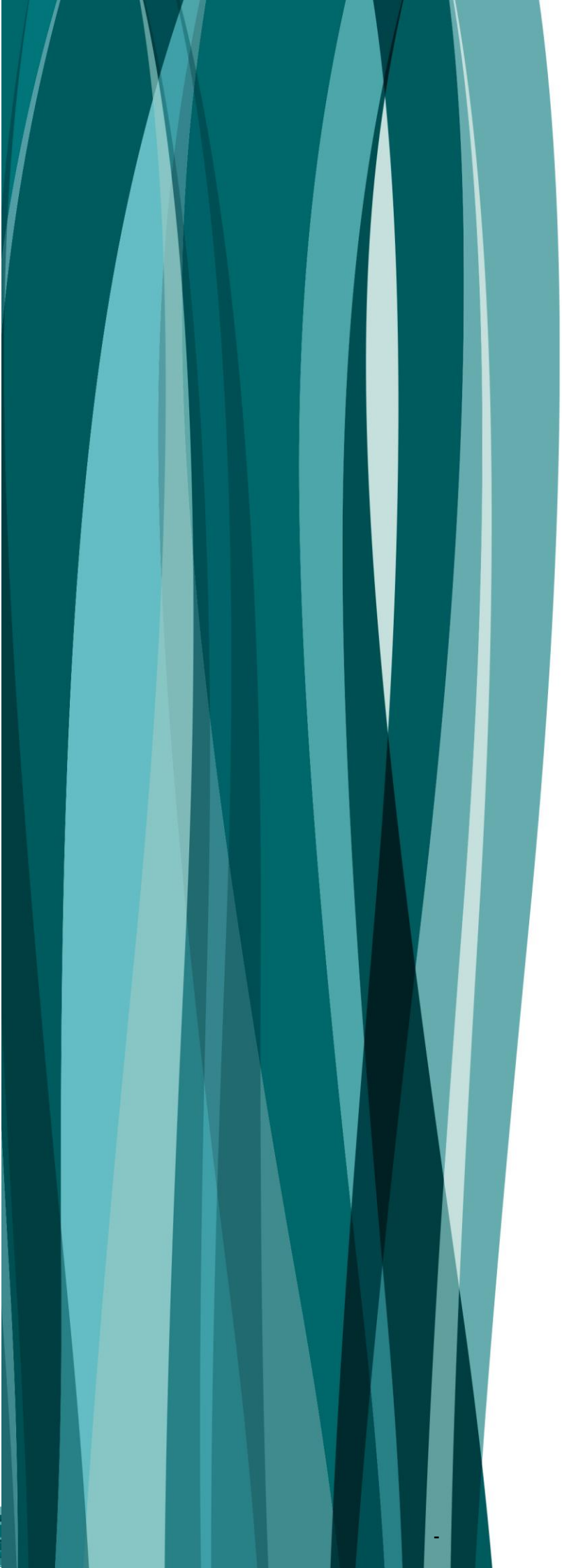
- Chief Psychiatrist Standing Order 8 - Urgent Circumstances Treatment
- Chief Psychiatrist Standing Order 9 – Seclusion
- Chief Psychiatrist Standing Order 10 - Chemical Restraint
- Chief Psychiatrist Standing Order 10A - Mechanical Restraint and Physical Restraint
- Chief Psychiatrist Standing Order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

Clinical Guidelines

The following Clinical Guidelines issued by the Chief Psychiatrist were in place as of 30 June 2024:

- Chief Psychiatrist Clinical Guideline 1 – Meaning of Mental Illness
- Chief Psychiatrist Clinical Guideline 2 – Capacity
- Chief Psychiatrist Clinical Guideline 3 – Representative and Support Person.
- Chief Psychiatrist Clinical Guideline 7 – Off-Label Use of Medications
- Chief Psychiatrist Clinical Guideline 8 - Urgent Circumstances Treatment
- Chief Psychiatrist Clinical Guideline 9 – Seclusion
- Chief Psychiatrist Clinical Guideline 10 – Chemical Restraint
- Chief Psychiatrist Clinical Guideline 10A - Mechanical Restraint and Physical Restraint.

These Approved Forms, Clinical Guidelines and Standing Orders are currently being reviewed and will be updated and made available in the next reporting period.



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