



Response

to the

Review of the Mental Health Act Review 1996 Discussion Paper

October, 2007

Introduction

Mental health around the world has historically operated in an environment of secrecy, compulsion, stigma and taboo. Its history is littered with abuses, some the most blatant and appalling in nature. Even today, advanced countries still continue to condone grossly inappropriate practices. But with the growing acceptance of international human rights principles, mental health has relatively recently undergone, and continues to undergo, radical changes which have obligated states to restrict or remove an individual's human rights in the most exceptional circumstances and only then, subject to the most stringent safeguards.

The *Mental Health Act 1996* (the Act) is authority for the state of Tasmania to mandate the legislative dispossession of a mentally ill citizen from their autonomous decision making capacity, their basic human rights to freedom of movement, and integrity of body. Most importantly, it is an Act intended to protect the vulnerable individual and safeguard their rights when the state does intervene in autonomous freedoms by involuntarily detaining and/or treating them.

Advocacy Tasmania is a consumer rights focused organisation and consequently, our interest in the proposed changes to the Act is predominately with regard to the afore mentioned stringent safeguards that the state should

afford its mentally ill citizens and whether proposed legislative 'safeguards' will translate into actual, enforced protections for persons receiving mental health services or whether the amended provisions will simply remain largely ignored ideological expression.

Areas not Addressed in the Discussion Paper

Tasmanians have been given the opportunity to enact model legislation relevant and current to the state and to the needs of its citizens. Instead, the Discussion Paper Recommendations appear as little more than a vehicle for setting in law the government's long held agenda with only tokenistic regard given to the many submissions it has received through the limited consultation process.

The rationale given as why these areas/topics were not addressed was that the "focus of the paper is on recommendations which will require significant alteration to current mental health legislation and address issues raised throughout the Issues Paper consultation process."¹ . This is not the case as many of the Recommendations such as Recommendation 3 demonstrate while other issues previously raised by Advocacy Tasmania as having detrimental affects on patients and their rights, and which do satisfy the requirement for significant alteration to current mental health legislation, have been ignored and left undiscussed.

S.39 provides for the transfer of involuntary patients between approved hospitals if the clinician considers the transfer to be either necessary or desirable. Necessity places on a clinician a greater obligation than desirability making 'necessary' superfluous as an element of the provision. The definition of care and treatment is so broad that it encompasses almost anything as being within its purview for instance bed availability when using a clinical/MHS perspective.

An established human rights principle is that detained persons should be accommodated as close to their home and family environment as is practicable. In Tasmania, it is impracticable to detain a prisoner near Burnie when the only prison in the state is situated in Hobart. This is not the case with approved hospitals which are regionally located.

The focus must be on the patient's rights and needs and therefore the onus must be on the clinician to establish why it is appropriate to transfer an involuntary patient. Appropriateness rests on reasons which need to be specifically linked to the individual's care and treatment and not simply to the clinical want to free up beds in Spencer by transferring involuntary patients to New Norfolk for example where there is more bed availability at the current time.

¹ Review of the Mental Health Act 1996 Discussion Paper, Department of Health and Human Services, August 2007, p.64

S.39(4) provides for a right to appeal to, and review by the Mental Health Tribunal. Presently, given the interpretational breadth of 'desirability' and 'care and treatment' the right to appeal is tokenistic. In practice, voluntary patients refusing to consent to a transfer are being placed on temporary involuntary orders to effect the desired transfer. Amending s.39 is necessary to stay its inappropriate and unmonitored use.

Advance Directives

The Discussion Paper's response to the issue of advance directives is very disappointing. It states that the Minister for Health and Human Services is supportive of advance directives being available to people with a mental illness² yet the government fails to take the opportunity to address the issue at the time when the Mental Health Act is being reviewed and the issue of treatment/consent/capacity is integral to the changes being proposed.

Rather than including mental health advance directives in future work undertaken for broader legislation change, work done now on mental health advance directives could have been used as the foundation for creating broader legislation change.

Given that it has taken seven years to achieve a partial review of the Act, it is not hopeful that the Act will be amended to include advance directives any time soon. The overwhelming support for advance directives has meant that it can not be ignored in the Discussion Paper however the consequence for Tasmania's mentally ill for some time to come is exactly the same as if it had been.

Human Rights

The Paper's very first recommendation, Recommendation 1, under the heading **Objects of the Act** calls for the inclusion of the following provisions:

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

The Principles for the protection of persons with mental illness and for the improvement of mental health care is an important international standard that

² *Ibid* p.64

was adopted by the UN General Assembly in 1991. The Principles have proved to be particularly valuable in incorporating into a single United Nations document specific to persons with mental illness and the situations affecting them, human rights established in earlier human rights instruments.

The Principles were used as the framework for the 1992 National Mental Health Strategy; 1994 Model Mental Health Legislation; 1996 Rights Analysis Instrument; 1996 National Mental Health Standards and countless other later documents and legislation including Tasmania's own *Mental Health Act 1996*.

In its 1992 Review of Mental Health Legislation Discussion Paper, the Tasmanian government stated that

The adoption of the Resolution 98b provides Tasmanians with a timely opportunity to establish legislation in keeping with **the latest** international standards for the protection of human rights. Many of the innovations proposed for a new Mental Health Act are derived from the Resolution 98b.³

The Discussion Paper recommends that the Objects should be broadened to reflect the aforementioned documents and should include a focus on human rights. It must be highlighted however that the Principles are now sixteen years old.

The human rights arena has not remained static during the past sixteen years and it's disappointing that this government has not acknowledged that fact and committed itself to examining, and possibly incorporating "the latest" human rights developments beyond the Principles⁴ into truly model Tasmanian mental health legislation.

It is difficult to try and reconcile how an Act that already embodies these rights, standards and principles can be broadened to embody these rights, standards and principles by adding a few words to the Objects of the Act. Or, how in practice, the inclusion of an express statement regarding human rights into the Objects of an Act that already embodies human rights will influence a greater respect for human rights?

While it is appropriate that human rights be enshrined in the Objects, it is deceptive to believe that the inclusion is anything more than a late addition ideological expression which will have no real impact on the lives of mental health patients in Tasmania.

Summary

Having analysed the Discussion Paper, we have become concerned that many of the Recommendations are unnecessary and/or superfluous. Others are

³ Review of Mental Health Legislation, Discussion Paper, Department of Health, April 1992, p. 2

⁴ Kingdon, D. et al Protecting the human rights of people with mental disorder: new recommendations emerging from the Council of Europe, *British Journal of Psychiatry* (2004) 185, 277-279

vague and lacking in detail. Overall, the recommendations fail to provide any real safeguards for the protection of the patient which was the consensus need expressed by responders to the Issues Paper.

Recommendations submitted by Advocacy Tasmania calling for discussion regarding the need for inclusion of provisions dealing with the use of chemical restraint for example have been ignored as has the call for discussion of monitoring the use of restraint and seclusion on voluntary patients.

Most noticeably, there is an absence of discussion on sanctions for breaching the Act although this was identified as necessary in numerous submissions because for the past 7 years many of the extant human rights and protection provisions within the present Act have been ignored or misused.

The Recommendations offer administrative changes to streamline services in the guise of human rights and to implement what ATI believes to be ill-considered Bridging the Gap promises such as the creation of the Office of the Chief Psychiatrist even if that means overlapping roles with established bodies and diverting funding from the already poorly funded and under resourced existing services that provide the vital although ever limiting, on the ground services to consumers.

The Discussion Paper fails to create an environment of transparency and accountability. Incident Reports are to be denied to the statutory body authorised to investigate patient's complaints. The rationale for this denial of evidence to the investigators is "to provide a level of confidence and security to encourage health care providers and managers to communicate openly and honestly with their colleagues in assessing the management, process and outcomes of health care practices".

This rationale is indicative of the tone of the Discussion Paper where strategic principles and objects of services, administrative efficiency and management are the themes wrapped in a covering of secrecy and compulsion. There is little that can be regarded as consumer focused or offering consumer protection.

Advocacy Tasmania Inc has not offered comment on all the recommendations for a number of reasons. As stated in the introduction, Advocacy Tasmania is a rights focused organisation and our responses have concentrated more on Recommendations and/or issues that have a direct impact on consumers.

The organisation is also not resourced sufficiently to comment on all recommendations and issues within the allocated six week period for response. Our input however has been a continual process since the review process began with both written and oral responses to draft issues and recommendations.

Recommendations

Recommendation 3

7. Principle of minimum interference with civil rights

In exercising powers conferred by this Act in relation to an involuntary patient, forensic patient or person subject to a supervision order or community treatment order, the following principles must be observed:

(a) restrictions on the liberty of the patient or person and interference with that patient's or person's rights, dignity and self-respect must be kept to the minimum consistent with the need to protect that patient or person and other persons and, in relation to a forensic patient, the good order and security of the secure mental health unit;

(b) effect must, **if practicable**, be given to that patient's or person's wishes so far as that is consistent with—

(i) that patient's or person's best interests; and

(ii) the need to protect that patient or person and other persons; and

(iii) in the case of a forensic patient, the good order and security of the secure mental health unit.

The term 'if practicable' must be removed. This should not have been included in the 1996 Act. Effect must be given so far as it is consistent with (a) and (b).

This is a right of the patient.

Recommendation 4

Advocacy Tasmania is not opposed to the ability to treat involuntarily detained patients without their consent. This power already exists at s. 32(2) of the *Mental Health Act 1996*.

There is an irony in the Discussion Paper's featuring of the 5, all encompassing situations, in which patients can presently be treated without their consent which must be a revelation to those commentators who have in the past claimed that the mentally ill in Tasmania can only be detained and not treated. Quite sensibly the government has shifted mid stream from its initial proposal to change the Act so that mentally ill persons can be treated when involuntarily detained to presenting the proposal to change the Act so that it reflects a focus on treatment rather than detention.

There are issues with the drafting of s.32(2).

- It only applies to patients who have a mental illness amenable to medical treatment. – Some patients are treatment resistant while others are being treated to control behaviours.
- S.32(2)(c) states that the treatment should be given to the patient in their own interests. This should have been drafted as 'best interests'.

Consequently, the GAB has avoided using s.32(2) in preference for the safeguards in the GAAA.

The rationale presents a deceptively poor argument, claiming that “legislative provisions have been specifically designed to override the common law situation that a person can refuse medical treatment when they fulfil the criteria for involuntary treatment.” What Tasmania is proposing is to take from the capacitated person their right to consent or refuse to consent to medical treatment. That right of the capacitated person is based on having capacity, not in being detained. If that were not the case, prisoners for example could be forcibly medically treated.

What is lacking in this recommendation is the detail, a deficiency replicated in many of the recommendation. What is an appropriate circumstance for example? It must be taken as accepted that the GAB already has the authority to decide in appropriate circumstances to allow an individual to refuse treatment otherwise the compelling of treatment would be a *fait accompli* upon application in every case in which the individual refused treatment.

As stated above, the Act already includes the ability to treat without consent so that Recommendation 4 in itself is unnecessary although it would have been appropriate to recommend the amendment of the present provision. It is also disappointing that the recommendation fails to give guidance with regard to what would be considered an appropriate refusal.

Recommendations 5 and 6

There is no ability for the person responsible to substitute consent to medical treatment in the *Mental Health Act 1996* so it can't be removed. There is the ability for a person responsible to substitute consent to medical treatment if a person **lacks the capacity to consent or refuse to consent** in the *Guardianship and Administration Act 1995*.

The present practice of clinicians in Tasmania has been to avoid the use of the MHA and circumvent its consent or GAB order requirements by using the GAAA medical treatment provisions. Under that Act, a person who lacks capacity can have a responsible person lawfully substitute their consent for medical treatment. The fundamental requisite is the lack of capacity which is often ignored by clinicians who view a refusal to consent as tantamount to a demonstration of a lack of capacity.

A major difficulty is that there is no review of capacity by the Guardianship Board unless the mentally ill person or their carer makes an application to the Board challenging the treatment decision. The Board will at that point determine the person's capacity to make the decision and if it finds that the person has capacity, there is no lawful authority under that Act to compel the person to undertake treatment. Presently in Tasmania, countless persons with capacity

are being compelled illegally through substitute decision-making to undertake treatment, a situation that must be remedied.

Advocacy Tasmania asks in what areas of human rights, legal decisions, or bodies of research has it been shown to be “considered to be a far more effective safeguard for the interests of the person with a mental illness than any decisions...about treatment for which they are unable to consent, are made by an independent tribunal?” This statement is medically paternalistic, stigmatising and contrary to law.

It is only when a conflict arises between interested parties as to whether a specific treatment should or should not be given to an incapacitated adult that the courts or tribunals consider that they have a role in care and treatment issues and then, only to decide as to the lawfulness of a doctor’s treatment decision.

... the Courts are not, contrary to what is sometimes believed, arbiters as to the merits of cases... Were we to express opinions as to the likelihood of the effectiveness of medical judgment, then we should be straying far from the sphere which under our constitution is accorded to us. We have one function only, which is to rule upon the lawfulness of decisions. That is a function to which we should strictly confine ourselves.⁵

The Recommendation does not refer to persons holding Enduring Powers of Attorney. In fact, it is appallingly vague. If the intent is to amend the GAAA legislation so that a person responsible for a mentally ill person lacking capacity is separated from all other persons lacking capacity based on mental illness being the cause of the lack of capacity, then this is discrimination at its worst. Advocacy Tasmania will vigorously oppose the amending of the GAAA to discriminate against mentally ill Tasmanians and their carers.

Recommendation 8

Clearly the opportunities will be limited for the person with the mental illness and appropriate others to be involved in the initial development of the plan that is presented to the tribunal for interim authorisation of a Treatment Order⁶.

It is concerning that the Discussion Paper recommends a paper review⁷ of the treatment plan within 72 hours. A Treatment Plan should be the result of a holistic approach to treatment from the treating team including other allied health professionals and should be broader than simply detailing medication. It should also include consultation with and the participation of patients and carers as dictated in MHS policy documents and legal expectations.

⁵ Sir Thomas Bingham MR in *R v. Cambridge Health Authority, ex p. B* [1995] 1 WLR 898 at 905A-B:

⁶ P.20

⁷ P.24

Generally in practice, a person admitted into an acute setting is brought to an approved hospital in protective custody. Often they are heavily medicated resulting in sleep or drowsiness for up to 48 hours. It is a difficult time for patients and for their carers if indeed carers have been made aware of the detention and treatment of the person for whom they are caring. Clearly, as the Discussion Paper notes, the opportunities will be limited for the person with the mental illness and appropriate others to be involved so what value is the plan to the patient at this time?

We must assume that clinicians do have a plan when treating a patient be they a mental health patient or a mainstream patient irrespective of whether there is a special document called a Treatment Plan in place. We must assume that when a clinician treats a patient be they a mental health patient or a mainstream patient, the doctor treats the patient in accordance with principles of best interests and the legal, clinical and ethical obligations that they are governed by.

A 'review' of the treatment plan at this point, without the patient in attendance, is contrary to the principles and objects contained within the Act. The patient is entitled by right to a proper assessment which can take days, sometimes weeks, and to a proper plan of treatment.

That the development of the plan should be ongoing is also a right of the patient. However, because a Treatment Plan should be a dynamic document does not give cause for not involving the patient and the carers. The creation of the plan can be vital considering that the patient may retain the right to give reasonable refusal to treatment and reasonable would include reasonable adverse experiential comments regarding the treatment proposed.

Questions

- Why is it necessary to submit the Plan to the Tribunal at all?
- Will it be the Tribunal's role to oversee the Plan and make decisions based on its clinical content?
- What would make the Plan deficient?
- What would be the expertise of the single Tribunal member to know that the Plan is appropriate or deficient?
- What powers would the sole Tribunal member have to tell a doctor to do it over again?
- Does this mean the patient is being denied necessary/beneficial treatment at this time?
- Is the submission of the Plan to the Tribunal merely an administrative form of proof that a Plan has been completed?
- If this is the case why should there be an expectation that the Plan is completed at this time taking into consideration the probable lack of involvement by patients and carers?

- Is this not simply a cause for extra administrative work, and cost for the Tribunal, to ensure doctors do what they are supposed to do?
- Does submitting the Treatment Plan within 72 hours offer patients any real protection or rather, does it have the potential to disempower, marginalise and actually cause harm to patients and carers?

The rationale given is lacking in detail and a convincing argument.

Recommendation 9, 10, 11, 12

Advocacy Tasmania is not opposed to a single order but there is no detail as to the how a single order would be implemented and what the safeguards of such an order would be. The Paper lacks the details called for in the responses to the Issues Paper.

Will the concepts of detention and treatment be separated and reviewed differently by the Mental Health Tribunal? There is no discussion in the Discussion Paper to suggest that this will be the case. And yet, the person may satisfy the criteria for detention while found able to reasonably refuse to consent to treatment.

Principle of Least Restrictive

It is disappointing that the Discussion Paper expressed the decision to disregard the growing wealth of research and debate regarding the effectiveness of community treatment orders and to use as its rationale for doing so, its commitment to the principle of least restrictive while failing to provide guidance as to its version of 'least restrictive'.

Principles provide basic statements about desirable values. In principlism, autonomy, beneficence, the avoidance of harm, and justice are featured because they involve nearly universally accepted values. In application however, principles may conflict so one or more may be violated or desirable outcomes may become misrepresented and unachievable . When this occurs, value is lost.

During the past 50 years, the least restrictive alternative has become the central ideology of mental health policies and legislation and underpins the *Principles for the protection of persons with mental illness and for the improvement of mental health care*. Accordingly, the pronounced principle of mental health policies and legislation is to treat mentally ill persons in non-hospital settings, collectively referred to as the community.

The least restrictive is a principle derived from three main ethical theoretical perspectives –liberalism, utilitarianism and communitarianism. From these main theories come various offshoots such as subjective utilitarianism, objective utilitarianism and egalitarian liberalism. How least restrictive is implemented in practice is based on which perspective is followed.

Under liberalism, the only scenario under which the government can be justified in implementing detention and/or treatment against a person's will is one in which the mentally ill person poses a danger to self or others or becomes significantly disadvantaged (defined in the Tasmanian MHA 1996 as representing a 'significant risk of harm'). These conditions have been widely accepted, and delineated within the civil commitment law of each jurisdiction.

Least restrictive relates to individual liberty through stated intervention. This is not simply confined to detention as is most commonly perceived. Individual liberty includes the right to bodily integrity, the right to make decisions and choices but there is no shared understanding of what least restrictive actually means.

In Tasmania, least restrictive is viewed narrowly within a hierarchical framework of setting and voluntariness. Voluntary admission and treatment is preferred to involuntary; and treatment in the community in preference to treatment in a hospital. This then begs the question of whose preference is used as the determinant.

But least restrictive is far more complex and encompassing. Taken from the mentally ill person's perspective, it may be less restrictive if the person was detained and treated involuntarily in a hospital for eight weeks rather than being treated involuntarily in the community for five years. It may be less restrictive to the person if they were on oral medication than on depot. But from a clinical perspective, it is considered to be more efficient (least restrictive on the system) to inject a person fortnightly than oversee and manage compliance and daily oral medication.

If least restrictive is to be a principle that the government is committed to keeping enshrined within the MHA, then more thought and discussion should have been given as to how it will be incorporated within the Act and how it is to be effected in practice rather than using it as a throw away response to why current research and debate is to be ignored.

This is not the forum to present theoretical argument around concepts such as free-market principles, cost-effectiveness analysis, market and cost-benefit analysis, egalitarian distribution of scarce resources, prevailing social values and ideological beliefs etc. But we trust that if the government is to follow a Recommendation based on the principle of least restrictive, it should have a clear understanding of what it is it is committed to, and why.

It is also expected that a Discussion Paper would explain fully why it chose to disregard one course in preference to following another, based on clear understanding, empirical evidence, analysis etc. A discussion paper requires at

least a modicum of discussion and the community is entitled to participate in that discussion. This has not been the case.

Recommendation 13

Advocacy Tasmania does not consider the model presented as a model that is focused on the needs and rights of the patient nor does it agree with the rationale for the model proposed.

Why is there a need for the Tribunal to 'authorise' treatment? Can not the Act in itself authorise treatment? Should not the focus be on ensuring that the rights of the patient have been respected and that clinicians have implemented treatment in accordance with the requirements of the Act?

This review is not a safeguard if the person is denied their right to be heard by the Tribunal. This is inconsistent with the Rules of Natural Justice espoused in the Act. The individual has a right to be brought before a court or tribunal. Principle 17(5) of the *Principles for the protection of persons with mental illness and the improvement of mental health care* states that "The patient and the patient's personal representative and counsel shall be entitled to attend, participate and be heard personally in **any hearing**." See also Article 10 of the Universal Declaration of Human Rights.

This is a reproduction of the s.65 Emergency Order in the GAAA. Under that Act, a clinician can telephone the GAB and speak to a member at which time they (the clinician) advises the member as to why they think that the person should be treated. The member makes the Order for 28 days. Ostensibly for this to occur, the person is required to lack capacity in accordance with the Act.

And yet, the statement is made in the Discussion Paper that "A guardianship model is considered to be more restrictive... [and] more appropriate for people with an on-going disability, that impairs their capacity".⁸

The question here again is what safe-guard or benefit is it to the patient for this Authorisation to be obtained if the patient does not have a voice? The answer is none. The authorisation only benefits the clinician in their ability to say "I had legal authorisation to treat my patient."

It is wrong for the Discussion Paper to be couching this recommendation in terms of protection of the rights of persons with mental illness or even the early involvement of an independent tribunal if the review is merely a paper review without participation by the represented person. There is no detail in the Paper to suggest it will be otherwise. In fact, there is no detail.

⁸ P.25

Recommendation 14

This Recommendation offers the criteria necessary to be met before the making of a Treatment Order. The paper states that it is “based on those in the Victorian *Mental Health Act 1986* and are similar to criteria uses in other states to determine the basis for involuntary treatment.”⁹

First it should be noted that the Victorian criteria was added to the 1986 Act on 1 July 1996 via the *Mental Health (Amendment) Act 1996 55/1996*. This in fact makes the criteria that the Discussion Paper is presently promoting more than a decade old, and older even than the criteria in the present Tasmanian Act. It appears that the suggestion is that Tasmania should go legislatively backwards.

Second, it is incorrect to state that this criteria is similar to other states particular as a number of states are in the process of reviewing their Acts. Below are some of the relevant provisions in the new New South Wales *Mental Health Act 2007*.

MENTAL HEALTH ACT 2007 - SECT 12

General restrictions on detention of persons

12 General restrictions on detention of persons

(1) A patient or other person must not be involuntarily admitted to, or detained in or continue to be detained in, a mental health facility unless an authorised medical officer is of the opinion that:

(a) the person is a mentally ill person or a mentally disordered person, and

(b) no other care of a less restrictive kind is appropriate and reasonably available to the person.

(2) If an authorised medical officer is not of that opinion about a patient or other person at a mental health facility, the officer must refuse to detain, and must not continue to detain, the person.

(3) An authorised medical officer may, immediately on discharging a patient or person who has been detained in a mental health facility, admit that person as a voluntary patient.

MENTAL HEALTH ACT 2007 - SECT 13

Criteria for involuntary admission etc as mentally ill person or mentally disordered person

13 Criteria for involuntary admission etc as mentally ill person or mentally disordered person

A person is a mentally ill person or a mentally disordered person for the purpose of:

(a) the involuntary admission of the person to a mental health facility or the detention of the person in a facility under this Act, or

(b) determining whether the person should be subject to a community treatment order or be detained or continue to be detained involuntarily in a mental health facility,

⁹ P.27

if, and only if, the person satisfies the relevant criteria set out in this Part.

MENTAL HEALTH ACT 2007 - SECT 14

Mentally ill persons

14 Mentally ill persons

(1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:

- (a) for the person's own protection from serious harm, or
- (b) for the protection of others from serious harm.

(2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.

MENTAL HEALTH ACT 2007 - SECT 84

Treatment may be given to patients

84 Treatment may be given to patients

An authorised medical officer of a mental health facility may, subject to this Act, give, or authorise the giving of, any treatment (including any medication) the officer thinks fit to an involuntary patient or assessable person detained in the facility in accordance with this Act.

MENTAL HEALTH ACT 2007 - SECT 68

Principles for care and treatment

68 Principles for care and treatment

It is the intention of Parliament that the following principles are, as far as practicable, to be given effect to with respect to the care and treatment of people with a mental illness or mental disorder:

- (a) people with a mental illness or mental disorder should receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given,
- (b) people with a mental illness or mental disorder should be provided with timely and high quality treatment and care in accordance with professionally accepted standards,
- (c) the provision of care and treatment should be designed to assist people with a mental illness or mental disorder, wherever possible, to live, work and participate in the community,
- (d) the prescription of medicine to a person with a mental illness or mental disorder should meet the health needs of the person and should be given only for therapeutic or diagnostic needs and not as a punishment or for the convenience of others,
- (e) people with a mental illness or mental disorder should be provided with appropriate information about treatment, treatment alternatives and the effects of treatment,
- (f) any restriction on the liberty of patients and other people with a mental illness or mental disorder and any interference with their rights, dignity and self-respect is to be kept to the minimum necessary in the circumstances,

(g) the age-related, gender-related, religious, cultural, language and other special needs of people with a mental illness or mental disorder should be recognised,

(h) every effort that is reasonably practicable should be made to involve persons with a mental illness or mental disorder in the development of treatment plans and plans for ongoing care,

(i) people with a mental illness or mental disorder should be informed of their legal rights and other entitlements under this Act and all reasonable efforts should be made to ensure the information is given in the language, mode of communication or terms that they are most likely to understand,

(j) the role of carers for people with a mental illness or mental disorder and their rights to be kept informed should be given effect.

The New South Wales Act in accordance with human rights developments already implemented in other areas, for example the Aged Care Charter of Resident's Rights and in mental health acts in other jurisdictions, includes a patient's and carer's rights Principles section.

Advocacy Tasmania is not offering up the New South Wales Act as a model but as a comparison to Tasmania's recommended changes and as an example of the thought, time, expertise and effort put into the review of that Act as opposed to Tasmania's review situation, and the genuine attempt to include current, relevant standards rather than outdated and adulterated reproductions.

The Discussion Paper recommends that a Treatment Order be made if

- a person **appears** to be mentally ill

With regard to detention, appearance of a mental illness is an acceptable criterion. The appearance of a mental illness justifies the person being taken into protective custody in the interests of their own wellbeing and safety, and in the interest of public safety, and the interests of a proper assessment.

The individual should be taken to a place of assessment to determine if they do have a mental illness and if so, what that illness is and what is the best plan of treatment for the individual. However, it is highly unacceptable as the basis for treating a person. It is unethical to treat a person when it is not even known that they have a treatable mental illness.

The recent Tasmanian Community Treatment Order amendments saw the inclusion of the s.40 criteria for making a CTO which quite correctly requires that **a) the person has a mental illness** before a treatment order can be made.

The problem has arisen from the government's plan to combine detention and treatment into one order which in itself is not problematic but the lack of thought given to the relevant criterions is. The government was advised that making

changes to one provision could have flow on affects for other provisions and that having the focus on streamlining could have negative affects on acceptable standards.

Further, the Recommendation has altered the already dated Victorian Act by adding the word welfare as an additional requirement to the patient's safety and health. In effect, this criteria states that for any reason whatsoever, a Tasmanian citizen who may or may not have an actual mental illness can be detained and forcibly treated. Could the criteria be made any broader and encapsulating and contrary to human rights?

Compare the recommendation to the Objects of the NSW Act;

3 Objects of Act

The objects of this Act are:

(a) to provide for the care, treatment and control of persons who **are** mentally ill or mentally disordered, and

(b) to facilitate the care, treatment and control of those persons through community care facilities, and

(c) to facilitate the provision of hospital care for those persons on a voluntary basis where appropriate and, in a limited number of situations, on an involuntary basis, and

(d) while protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care, and

(e) to facilitate the involvement of those persons, and persons caring for them, in decisions involving appropriate care, treatment and control.

Clearly, the developments in human rights that have "obligated the state to restrict or remove an individual's human rights in the most exceptional circumstances and only then, subject to the most stringent safeguards" have failed to reach Tasmania which rather than seeking to limit, aims to expand its control over its citizens despite its proffering of ideological expression.

Advocacy Tasmania does not oppose involuntary treatment but it does oppose this criteria on the basis that it is poorly considered; inconsistent with the other provisions in the Act; dated; fails to offer connective safeguard provisions that are found in other Acts; and strips basic rights from mentally ill persons and persons who appear to have a mental illness through a dated medical model criteria reminiscent of decades past and the troubled asylum.

Recommendation 15

Detention is not treatment by any definitional stretch of the imagination and Advocacy Tasmania will vigorously oppose its inclusion as such. The attempt to include detention in the definition of treatment adds to the stigma already associated with mental illness and is contrary to any therapeutic definition of what is treatment. There are very good and obvious reasons as to why "other

jurisdictions' have not included detention as a treatment. That it is proposed that Tasmania should be the first is shameful.

The rationale given in the Discussion Paper is simply skirting around issues of preventative detention and criminal justice legislation masquerading as mental health legislation. That detention might be necessary for the control of certain individuals is a fact and for this reason modern Acts have headings such as "PART 1 - REQUIREMENTS FOR INVOLUNTARY ADMISSION, DETENTION AND TREATMENT" and provisions that refer to the **care, treatment or control** of mentally ill individuals.

Detention

The Paper again has ignored discussion of treatment resistant individuals which has been an issue raised by Advocacy Tasmania on a number of occasions.

What protections will be in place for mentally ill individuals who cannot be treated and who are simply being contained in the public interest?

Recommendation 16

It is disappointing that so many of the Recommendations remove from public discussion the "additional safeguards because of the potential for serious implications for the patient"¹⁰ and removes them to the secrecy of *ad hoc* decision-making through Regulations, Standing Orders, privilege of quality assurance policies etc.

Recommendation 17

The doctrine of urgent and necessary is established at common law and available to every doctor. In practice in Tasmania, many if not most involuntary and non compliant persons are forcibly treated upon admission under this doctrine.

What is required in statutory form is legal guidance for clinicians, and others as what constitutes urgent and necessary under this Act. A common definition is below;

- Which is immediately necessary to save the patient's life; or
- Which (not being irreversible) is immediately necessary to prevent a serious deterioration of his condition; or
- Which (not being irreversible or hazardous) is immediately necessary to alleviate serious suffering by the patient; or
- Which (not being irreversible or hazardous) is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or to others.

¹⁰ P.30

Section 40 of the GAAA legislatively enshrines the common law 'urgent and necessary' doctrine into Tasmanian statute. However, the decision to provide urgent and necessary treatment is an ethical and clinical decision appropriately made by the clinician examining the person at the time. Making such a decision is not, and should not be confined to a mental health approved hospital facility.

There is a wide chasm between urgent treatment and ongoing treatment which is not reflected in this Recommendation. There is also a marked difference between urgent medical treatment that can be lengthy (eg a car accident victim with head injuries being treated in an intensive care unit of a hospital in an attempt to **a**) primarily save the person's life and **b**) stabilize their condition) and ongoing psychiatric treatment.

One has to wonder why there is a necessity to include "and where authorisation is provided by the Chief Psychiatrist or delegates". This appears superfluous to the principle. If the Chief Psychiatrist or his delegate has not examined the patient so as to establish 'immediacy and necessity' are they then simply relying on the examination and opinion of another clinician, or other?

The detail in this rationale is sorely lacking however, it could be surmised that the Chief Psychiatrist is taking advice over the phone from, for example, a nurse or ambulance officer. What then would be the protections given to the patient in such exchanges of advice regarding for example, levels of competence and training?

On the face of it this Recommendation –

- Demonstrates a lack of understanding of the doctrine of urgent and necessary
- Is contrary to the doctrine of urgent and necessary
- Seeks to broaden the powers of the state over the individual beyond the doctrine of what is urgent and necessary
- Runs counter to the principle of minimum interference with civil rights
- Can be considered to be authorising chemical restraint
- Does not offer any real protections to the individual
- Does not detail any safeguards
- Pads up the tasks for the creation of the role of Chief Psychiatrist in Tasmania
- Uses as argument support the role and power of the Chief Forensic Psychiatrist which was a role developed by the government and presented to the community in a large, complex Bill that allowed for three days public comment.

Recommendation 18

The obvious question that arises is what exactly will be different under this amendment than is presently the case as many clinicians do not now comply with their legal obligations. What sanctions will apply for failure to follow the requirements of the Act?

Recommendation 19, 20, 21

Advocacy Tasmania applauds Recommendations 19 and 21 because of their acknowledgement of the complexities, and the legal importance associated with informed consent and we welcome further investigation and consideration.

Recommendation 20 however demonstrates a failure to understand the concept of informed consent. That it recommends that doctors “make a note in the client file that the nature and effect of the treatment has been explained to them” most clearly identifies the haste with which the process of reviewing the Act has been forced to be undertaken and the lack of expertise given to the process.

Decisional capacity is defined as the “mental ability to understand the nature and effects of one’s acts” and refers to a medical-legal construct to be determined by a clinician. Debate over the ethics of informed decision making in medical treatment has engaged the medical and legal professions for years with particular attention focused on psychiatric patients.

The responsibility first is on the clinician to provide the patient with full and frank information regarding the proposed treatment including treatment alternatives, side affects, consequences of non treatment, prognosis with treatment etc. The clinician then ‘tests’ the patient to determine whether the patient understands the nature and effect of the proposed treatment. If they do, they have the capacity to give consent, or refuse to give their consent, and if they don’t they cannot give consent at all. Compliance is not consent.

The capacity to give consent or refuse to give consent can fluctuate. A consent given at the time a person had capacity does not necessarily mean that the consent continues indefinitely if the person loses the capacity to consent or withdraw their consent.

Many of Tasmania’s clinicians do not have sufficient understanding of how to determine capacity or the requirement for competence, or the appropriate processes necessary to establish an informed consent. There is a need for training and proper guidance.

Other jurisdictions include detailed provisions relating to Informed Consent within their Acts. They do not relegate such important detail behind the administrative barrier of Standing Orders. This is another example of trying to create tasks for the role of Chief Psychiatrist.

Below is Section 7 of the Northern Territory Mental Health Act dealing with informed consent -

- (1) A person cannot give informed consent under this Act unless this section is complied with, and any attempt to waive or circumvent the requirements of this section is of no effect.
- (2) A person gives informed consent under this Act—
 - (a) when the person's consent is freely and voluntarily given without any inducement being offered;
 - (b) the person is capable of understanding the effects of giving consent; and
 - (c) the person communicates his or her consent on the approved form.
- (3) A person can give informed consent only when he or she has been given—
 - (a) a clear explanation of the assessment and possible diagnosis, the nature of the proposed treatment, including sufficient information about the type of treatment, its purpose and likely duration to permit the person to make a balanced judgment regarding undertaking it;
 - (b) an adequate description, without concealment, exaggeration or distortion, of the benefits, discomforts and risks associated with the treatment;
 - (c) an adequate description of any appropriate alternative form of treatment that is reasonably available;
 - (d) a clear answer to all relevant questions asked by the person (and the answer has been understood by the person);
 - (e) advice that the treatment may be refused or consent may be withdrawn at any time while the treatment is being undertaken;
 - (f) advice that independent legal or medical advice may be obtained in relation to the treatment before giving consent (and reasonable assistance is provided to obtain that advice, if requested);
 - (g) advice of all rights of review and appeal under this Act;
 - (h) advice of any relevant financial advantage that may be gained by a medical practitioner proposing the treatment and by the approved treatment facility or approved treatment agency where the treatment is to be undertaken;
 - (j) advice of any relevant research relationship between a medical practitioner proposing the treatment and the approved treatment facility or approved treatment agency where the treatment is to be undertaken; and
 - (k) explanations, descriptions and advice in a manner or form that the person is used to communicating in (and due regard is to be given to age, culture, disability, impairment and any other factors that may influence the person understanding the explanation).
- (4) A person must be given adequate time to consider the information provided under subsection 3 before being asked to give his or her informed consent.

And Section 53B from the Victorian legislation –

Requirements for obtaining informed consent

53B. Requirements for obtaining informed consent

(1) For the purposes of this Part (other than section 83(2)), a person is to be taken to have given informed consent to the performance on him or her of treatment only if the person gives written consent to that treatment after-

- (a) the person has been given a clear explanation containing sufficient information to enable him or her to make a balanced judgement; and
- (b) the person has been given an adequate description of benefits, discomforts and risks without exaggeration or concealment; and
- (c) the person has been advised of any beneficial alternative treatments; and
- (d) any relevant questions asked by the person have been answered and the answers have been understood by the person; and
- (e) a full disclosure has been made of any financial relationship between the person seeking informed consent or the registered medical practitioner who proposes to perform the treatment, or both, and the service, hospital or clinic in which it is proposed to perform the treatment; and
- (f) sub-sections (2) and (3) have been complied with.

(2) The person on whom the treatment is to be performed must be given the appropriate prescribed printed statement-

- (a) advising the person as to his or her legal rights and other entitlements including-
 - (i) the right to obtain legal and medical advice (including a second psychiatric opinion) and to be represented before giving consent; and
 - (ii) the right to refuse or withdraw his or her consent and to discontinue all or any part of the treatment at any time; and
- (b) containing any other information relating to the treatment that the Department considers relevant.

(3) In addition to the statement, the person must be given an oral explanation of the information contained in the statement and, if he or she appears not to have understood, or to be incapable of understanding, the information contained in the statement, arrangements must be made to convey the information to the person in the language, mode of communication or terms which he or she is most likely to understand.

(4) The statement may be printed in different languages so that, whenever possible, a person can be given a copy of the statement in a language with which he or she is familiar.

(5) It is the duty of the authorised psychiatrist to ensure that this section is complied with in the approved mental health service.

Note: In considering whether a person has given informed consent to treatment, see also section 3A.

Recommendation 23

S. 2 of *Mental Health (Compulsory Assessment and Treatment) Act* 1992, the New Zealand legislation referred to in the Discussion Paper does not define mental illness but in fact defines mental disorder.

Mental disorder, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it—

- (a) Poses a serious danger to the health or safety of that person or of others; or
- (b) Seriously diminishes the capacity of that person to take care of himself or herself;—

and mentally disordered, in relation to any such person, has a corresponding meaning:

Generally, definitions of mental disorders or mental illness in mental health legislation in other States and Territories, with some variation, read as:

For the purposes of this Act a person has a mental illness if the person suffers from a disturbance of thought, mood, volition, perception, orientation or memory that impairs judgment or behaviour to a significant extent.

The definitions exclude social lifestyle choices, sexual preferences, and political views. In addition to the mental health legislation that applies to people with a mental illness, the States and Territories also have guardianship legislation, which applies to everyone who is incapable of making their own decisions.

While the current Tasmanian definition uses the term mental illness, it actually satisfies the legislative preference for the use of mental health disorder. The Model Mental Health Legislation also referred to in the rationale suggested that provision be made for a person with a personality disorder alone or with other mental disturbances to be involuntarily admitted for a brief period of up to 10 days to a mental health facility on the grounds of 'mental disorder'.

Both the NSW & NT mental health acts have similar provisions for brief detention to those suggested by the Model Legislation. These provisions

enable a person who does not fulfill the criteria for involuntary admission on the grounds of mental illness but whose behaviour is so irrational or disturbed as to lead to the conclusion that the person is experiencing a severe impairment of a nature requiring psychiatric assessment, treatment or therapeutic care to prevent further serious mental or physical deterioration.

The reason for this short-term detention is to permit medical and mental health intervention in times of crises or where a person needs assessment but it is unclear what is wrong. Mental health professionals are able to determine whether a person might have an underlying mental illness which should be treated or whether other assistance can be provided. It also assists the person to get through the crisis and to engage with mental health case-management or support services in the community.

Within a clinical context, mental illness can be defined as a clinically recognisable set of symptoms relating to mood, thought, or cognition or behaviour that is associated with distress and interference with functions that is, impairments leading to activity limitations or participation restrictions.

Example

- dementia, delirium and other organic mental disorders;
- schizophrenia, bipolar disorder and other related psychotic disorders that are characterised by hallucinations, delusions, thought disorders, behaviour disturbances;
- mood disorders, especially depression;
- anxiety disorders;
- substance use disorders; and
- personality disorders that are characterised by enduring patterns of behaviour that are inflexible and maladaptive and cause distress or interference with functions.

The planned departure from mental illness of personality disorders and dementia as demonstrated in the Discussion Paper's Recommendation 23 reflects psychiatry's continuing marginalization within medicine on an outdated mind/body or illness/disease split. This underlines one of the psychiatrist's roles as the vehicle to 'medically' explain abnormal behaviour. This model means that behaviour, once explained in terms of disease as opposed to illness, can be moved from the direct responsibility of psychiatry into other areas of medicine.

It would have been appropriate that during the Review, discussion had taken place as to the increasing number of groups being disenfranchised from the Tasmanian mental health system. Consideration should have been given to whether changes to the Act needed to include provisions for assisting people with personality disorder and dementia against their will.

By removing S.4(d) and adding further exclusions, the intention is abundantly clear that the state's psychiatric services will be unavailable to these groups. This raises the question as to how and when the government intends to create and fund the separate services necessary for the care, treatment, habilitation and control of persons with a PD diagnosis and dementia or is it expected that the criminal justice system will provide the necessary services?

Recommendation 24

What is being said in this recommendation is that the lawful right via a Guardianship Order or an Enduring Guardianship of a person authorised to substitute consent for a person who lacks capacity is to be disregarded and the person is going to be involuntarily dealt with causing the same ethical problems and legal difficulties that presently exist for those persons detained against their will as a voluntary patient.

The terms involuntary and voluntary should be removed from the Act as the admission rests on the will of the patient or their legal substitute decision maker and the giving or refusing of their consent. If the person is admitted formally consent plays no part in the admission which then rests with the will of the clinicians. This overcomes the problems associated with the rights of Guardians and Enduring Guardians.

Advocacy supports the entry to an in-patient facility by formal order for persons who do not have the mental or legal capacity to give their consent. However, the rationale is one-dimensional and simply ignores the rights at law of persons authorised to give consent while it maintains the voluntary/involuntary concepts.

Recommendation 27

The rationale for this recommendation is based on a deterioration of mental health where the voluntary patient will satisfy the criteria for involuntary admission. However, the involuntary order is only triggered when the person seeks to discharge themselves from the facility.

Ethically, if a voluntary patient's mental health deteriorates sufficiently to satisfy the involuntary criteria, it should be at this assessment point in time that they are placed on an involuntary order. If this is not the case, it can be assumed that there will be many voluntary patients who for significant periods of time who do not satisfy the definition of a voluntary patient ie: they are not there of their free will and able to leave when they choose.

This state of existence is contrary to human rights law.¹¹ Nor does it satisfy the spirit of the principle of least restrictive. This recommendation has failed to deal adequately with this issue.

¹¹ European Court of Human Rights *H.L. v. the United Kingdom* (application no. 45508/99) 2004

Recommendations 28, 29 and 30

These recommendations do not provide safeguards, add little to the already existing provisions in the Act, and do not change practices.

Eg.

Presently a police officer will take a person into protective custody, transport them to Emergency Medicine at the RHH where a medical registrar (often lacking in psychiatric training) will examine the person after a few hours and often tell police that they are not going to be admitted. Often this decision is made because the person's medical file states that they do not have a mental illness but have a personality disorder etc.

Recommendation 31

- a) This broadens authorised officers to include ambulance officers who can take the person to the hospital to have them refused admission. Interestingly, unlike police who have other powers what will ambulance officers do in these situations? This recommendation fails to provide any detail or protections for the patients, or the authorised officers who have taken an individual into protective custody.
- b) Advocacy Tasmania applauds the mandatory education and training of authorised officers but this must be ongoing and not a one off.

Recommendation 32

This language in this recommendation is obtuse. It should read as clear as the rationale for Recommendation 31 a) that being that police involvement is only requested by authorised officers if the person is considered dangerous or violent. Correctly, the onus would be on the authorised officers to demonstrate this belief as being reasonable and evidentially based. There needs to be a form of accountability, and monitoring if police do attend incorporated into the Act

Recommendation 33

This recommendation and rationale is poorly explained and appear to offer all things to all people.

Carer's have the right to be involved in the development of treatment plans and discharge plans, not merely give a copy of the treatment plan especially if they are involved in the giving of practical daily care once the patient has been discharged from hospital. This form of carer could be a family member with whom the patient lives or the community accommodation and support service provider such as Richmond Fellowship where the patient resides. It can be vital that this sharing of information occurs if the patient is to be guaranteed a continuum of care.

A difficulty lies however in the use of the term carer because it can be applied to any person who 'cares' about the patient such as a close relative even though they do not have a close relationship with the person.

Example

A mother loves her 38 year old son and is genuinely interested in his care and treatment but because of various factors which may include his mental illness, she has little influence in his life. Does this person have a right to know the patient's private health details if he has capacity and chooses to refuse his consent for his private details to be shared with her?

What does "unless it is determined that this would be contrary to the patient's best interests for this to occur. The best interests of the patient are to be informed by the patient's wishes" mean? Is it that if the patient refuses to consent, then the "copy of the treatment plan" will not be provided to the carer? If so, what has this to do with best interests?

It appears that anyone who is a family member, carer, or significant other who expresses an interest in the patient is to be given copies of treatment orders etc. Will this occur without the patient's consent? Is the decision making occurring around the patient's privacy and confidentiality rights to be made by clinicians?

What was required in the Recommendations was clear guidance as to the rights of patients and their carers, not a return to the medical model behind the *Mental Health Act* 1963.

Recommendation 35

The Act only refers to restraint as "bodily restraint" defined in s.3 to mean "a form of physical or mechanical restraint that prevents the free movement of the limbs". The Act does not include reference to chemical restraint which is the intentional use of medication to control a person's behaviour.

It is disappointing that the universally accepted need for safeguards regarding chemical restraint to be included in the Act has continually gone ignored within this review.

Advocacy Tasmania once again calls for the Act to be amended to include chemical restraint in the definition of restraint within the Act.

Recommendation 36

Although nothing in the Act authorizes a facility to detain or restrain an informal or voluntary patient [Section 14], such patients are at times restrained. Authority for the temporary restraint of voluntary or informal patients is derived from either the common law or other, applicable statutes. At common law, facilities may employ restraint in

circumstances where necessary to protect the patient or others in the facility. The risk of harm must be imminent and the form and extent of restraint must be reasonable, given all factors. Restraint, therefore, must be applied for only as long as necessary to remove immediate risk.

Review of Seclusion and Restraint Practices
in Ontario Provincial Psychiatric Hospitals, October 2001

Voluntarily admitted patients may also require restraint and seclusion in emergency situations. It may then be necessary to certify the patient for involuntary admission, depending on local regulation and statute, since a voluntary patient is presumed to have a right to refuse treatment and request discharge from the hospital. In other jurisdictions, the use of short term restraint or seclusion for voluntary patients is permissible without certification and subsequent commitment.

B.. Weiner, R., Wettstein, *Legal Issues in Mental Health Care*, Springer, 1993 p.135

- It is a fact that restraint and seclusion are increasingly considered world wide by mental health professionals to be the most draconian methods of patient control in mental health settings and many jurisdiction no longer authorise these forms of patient control or actively oppose the use of restraint and seclusion as dated restrictive practices.
- It is a fact that jurisdictions and mental health facilities that use these techniques should do, or should do so as a last resort.
- It is also fact that there is a legal view that seclusion and restraint is treatment which can be evidenced by the holding in the Queensland Supreme Court decision in *Re Langham and Adult Guardian and State of Queensland and Director of Mental Health* [2005] QSC 127. Treatment is available to all patients and is not dependent on involuntary status.

The extract below is taken from a current Mental Health Facilities Handbook.

Keep in mind that seclusion and restraint are involuntary procedures. They should not be used with voluntary individuals. However, if the staff decides to use seclusion or restraint on a voluntary individual, the individual must be placed on an involuntary hold, and a petition for civil commitment filed the next business day.¹²

- It is a fact that seclusion and restraint are used on mentally ill Tasmanians who are voluntary patients in Tasmanian facilities. It may be used as a necessary involuntary behaviour management technique or as part of a voluntary behaviour management plan. It may be used to

¹² <http://www.nmpanda.org/selfadv/pami/minorrts.html>

reduce environmental stimuli as deemed clinically necessary. It may be requested by patient as 'Time Out'. People are also admitted voluntarily to general wards such as the neurological ward who are subjected to restraint and seclusion.

It is naïve to believe that a person who is sufficiently mentally unwell so as to require hospitalisation in an acute setting is not at risk of demonstrating behaviours that are aggressive, inappropriate and dangerous. Considering that the Act has a preference for voluntary admission, it is likely that many patients who satisfy involuntary admission but who have a voluntary status because they have consented to admission or who have been compliant at the time of admission demonstrate behaviours that clinical staff would assess as requiring seclusion or restraint at times.

If restraint and seclusion are to continue to be used in approved hospitals and other mental health facilities, then all patients should be protected by the Act irrespective of status. To deny voluntary persons subjected to restraint or seclusion in approved hospitals the protections of the Act is discriminatory.

Advocacy Tasmania calls for the Act to be amended to –

- Make it unlawful to restrain or seclude voluntary patients
or
- Ensure that the protections afforded by the Act are not so afforded on the basis of a patient's voluntary or involuntary status but on the basis of the patient being secluded or restrained.

Recommendation 44

The Act must ensure that persons who wish to appeal to the Supreme Court are entitled to free representation to do so otherwise it is an empty right of no benefit to the vast majority of persons subjected to involuntary orders, or their carers. Mental Health Services will be able to afford representation and will be so represented at any appeal. There needs to be an equal field for parties of an appeal.

Recommendation 46

Tasmania presently has a Scheme in place that provides free and competent representation to all persons appearing before the Mental Health Tribunal. The rationale has stated that government funding to Legal Aid "will be **in addition** to the representation currently provided by Advocacy Tasmania's Mental Health Tribunal Representation Scheme".

There is no detail in the Recommendation regarding how the Act will provide for 'increased legal representation'? Considering that a Bill is presently being drafted, it is disappointing that there has been no communication with Advocacy

Tasmania as to how such a Legal Aid Scheme would be implemented to co-exist with the MHTRS.

If a Legal Aid Scheme is to run alongside the present MHTRS, it is fundamental that the MHTRS has statutory acknowledgement alongside Legal Aid. It is difficult to comment further on this recommendation as it is devoid of all detail.

Recommendation 51

The rationale for this recommendation is that the aim is “to provide a level of confidence and security to encourage health care providers and managers to communicate openly and honestly with their colleagues in assessing the management, process and outcomes of health care practices.” Where is the client focus in such a process?

This recommendation is an abuse of a person’s right to a proper investigation of their complaint, and to a fair hearing. It runs counter to the spirit of legislation intended to safeguard the rights of patients rather than to support star chambers under the guise of quality assurance.

Recommendation 52, 53, 54, 55, 56 and 57

Just because the role of Chief Psychiatrist exists in other jurisdictions does not make it a necessity for a small state like Tasmania. There is a wealth of complaints about the Office from other jurisdictions mainly to do with impartiality. However, other jurisdictions have an office with administrative support and investigators. Other states have stronger rights foci than Tasmania and have funded and committed entities and organisations that comment on the actions of the Office of the Chief Psychiatrist.

The recommendation to create a position of Chief Psychiatrist is a costly and administratively cumbersome exercise, and an unnecessary doubling up of roles with the Mental Health Tribunal and Official Visitors although there is no detail offered that outlines the intent to establish an Office but to simply name an individual employed by MHS as Chief Psychiatrist.

There is the potential for conflict in oversight roles. There is no indication that the creation of this role will be of advantage to mental health patients and the costs associated with creating and maintaining this role would be better spent on consumers and improving services.

The use of Standing Orders is unsuitable and unacceptable in dealing with matters that are assaults and deprivations of liberty if unlawful.

Recommendation 60

This recommendation refers to a young person not being admitted more broadly to a secure unit rather than narrowly to the Wilfred Lopez Centre, the only forensic secure mental health unit in the state.

The Act allows young people to be admitted voluntarily and involuntarily to approved hospitals. Present facilities have secured units (such as Tyenna Blue) or areas (such as High Dependency Units) none of which are able to separate young people from adults.

This raises obvious questions.

- Is there an intention to deny young people much needed care and treatment on the basis that they can not be separated from adults?
- Is there an intention by MHS to build facilities across the regions specific to the needs of this group of young people needing a secure treatment environment?

Summary

The Discussion Paper fails to detail any new safeguards for mentally ill individuals compelled under the *Mental Health Act 1996* as was called for by the many individuals and organisations during the consultation process. Nor has it offered any sanctions for breaches of the Act.

The provision of mental health services in Tasmania is in crisis. The percentage of the population requiring services is ever increasing while the ability to provide service is decreasing. The lack of sufficient funding for maintaining present levels of service and the inability to attract and retain a well trained workforce are indicative of the problems experienced worldwide and have necessitated the development of strategies to make services more efficient.

The Discussion Paper noticeably has incorporated these strategies into proposals for legislative change and couched many of them in the guise of human rights. The Paper is however, most obvious for what it has not discussed or recommended than for what it has. It is a disappointing document which has missed the opportunity to engender current and relevant debate and to make real human rights changes in Tasmanian mental health.