TASMANIA

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MENTAL HEALTH BILL 2012

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MENTAL HEALTH BILL 2012

(Brought in by the Minister for Health, the Honourable Michelle Anne O'Byrne)

A BILL FOR

An Act to provide for the assessment, treatment and care of persons with mental illness, to repeal the *Mental Health Act 1996*, to repeal and rescind some related legislation and for related purposes

Be it enacted by His Excellency the Governor of Tasmania, by and with the advice and consent of the Legislative Council and House of Assembly, in Parliament assembled, as follows:

CHAPTER 1 – PRELIMINARY

PART 1 – SHORT TITLE AND COMMENCEMENT

1. Short title

This Act may be cited as the *Mental Health Act 2012*.

2. Commencement

The provisions of this Act commence on a day or days to be proclaimed but, if not all of the provisions have commenced before 1 January 2014, the provisions of this Act that have not commenced before that date commence on that date.

PART 2 – INTERPRETATION

3. Interpretation

(1) In this Act, unless the contrary intention appears –

Aborigine means an Aboriginal person within the meaning of the *Aboriginal Lands Act 1995*;

adult means a person who has attained the age of 18 years;

ambulance officer means an officer of the Ambulance Service within the meaning of the *Ambulance Service Act 1982*;

appropriate record, of any matter, means a record of the matter that sets out relevant particulars and circumstances;

approved assessment centre means an assessment centre that is approved under section 140;

approved facility means an approved hospital, an approved assessment centre or a secure mental health unit;

approved form – see subsection (2);

approved hospital means a hospital approved under section 140;

approved medical practitioner – see section 138;

approved nurse – see section 138;

assessment criteria means the criteria set out in section 25;

assessment order means an assessment order made under Division 1 of Part 3 of chapter 2;

authorised person – see section 109;

CCP means Chief Civil Psychiatrist;

CFP means Chief Forensic Psychiatrist;

chemical restraint means medication given primarily to control a person's behaviour, not to treat a mental illness or physical condition;

Chief Civil Psychiatrist means the person for the time being holding or acting in the office referred to in section 143;

Chief Forensic Psychiatrist means the person for the time being holding or acting in the office referred to in section 144;

Chief Psychiatrist means the Chief Civil Psychiatrist or Chief Forensic Psychiatrist;

child means a person who has not attained the age of 18 years;

clinical guidelines – see section 151;

clinical reasons, for granting any patient a leave of absence under this Act, include –

(a) facilitating the patient's rehabilitation or reintegration into the community; and

(b) furthering the patient's treatment; and

(c) reasons deemed appropriate by the person authorised to grant the leave;

controlling authority means –

(a) for an approved facility run by or on behalf of the State, the Secretary; and

(b) for any other approved facility, the person for the time being in overall charge of the day-to-day clinical management of that facility;

custody and escort provisions means the custody and escort provisions in Schedule 2;

decision-making capacity – see section 7;

Deputy President means the Deputy President of the Tribunal;

Deputy Public Guardian means the Deputy Public Guardian under the *Guardianship and Administration Act 1995*;

Director means the Director of Corrective Services;

disability means any restriction or lack of ability to perform an activity in a normal manner (being a restriction or lack of ability arising from any absence, loss or abnormality of mental, psychological, physiological or anatomical structure or function);

eligible person means a person registered in relation to a particular forensic patient in the Eligible Persons Register;

Eligible Persons Register means the register kept under section 87A of the *Corrections Act 1997*;

financial year means the 12-month period ending on 30 June in any year;

forensic patient means a person admitted to an SMHU under section 68 and not discharged from the SMHU;

general health care means medical, dental or other health treatment not primarily aimed at the treatment or alleviation of mental illness;

give, a document to any person, includes causing the document to be given to the person;

government premises means premises run by or on behalf of the State;

guardian has the same meaning as in the *Guardianship and Administration Act 1995*;

Health Complaints Commissioner means the person for the time being holding or acting in the appointment referred to in section 5 of the *Health Complaints Act 1995*;

health professional means a person registered under the Health Practitioner Regulation National Law (Tasmania) in any profession;

informed consent, to assessment or treatment – see sections 8 and 9;

involuntary patient means a person who is subject to an assessment order or treatment order;

make, a record, includes causing the record to be made;

mechanical restraint means a device that controls a person's freedom of movement;

member means a member of the Tribunal;

mental health officer means a person who, under section 139, is a mental health officer for the provision in which the expression is used;

mental health service delivery principles –see section 15 and Schedule 1;

mental illness – see section 4;

MHO means mental health officer;

MHT means the Mental Health Tribunal established under section 167;

MHT guidelines – see section 169;

MHT staff member means a State Servant whose services are made available to the Tribunal pursuant to section 176(2);

Minister for Health means the Minister assigned primary responsibility for health;

notice means written notice;

nurse means a registered nurse or enrolled nurse;

Official Visitor means a person for the time being holding an appointment under section 155(2);

parent, of a child, means a person having, for the child, all of the responsibilities which, by law, a parent has in relation to his or her children;

patient means, according to the context, a voluntary inpatient, involuntary patient or forensic patient and, in Part 6 of chapter 2, includes a voluntary patient;

personal reasons for granting any patient a leave of absence under this Act include –

(a) visiting a sick or dying relative or close friend; and

(b) attending the funeral of a relative or close friend; and

(c) attending a wedding or graduation of a relative or close friend; and

(d) attending a family occasion of special importance; and

(e) if the patient is an Aborigine, attending an event of cultural or spiritual significance to Aborigines; and

(f) attending a special religious event or service; and

(g) attending a reunion or commemoration;

physical aids includes –

(a) spectacles and hearing aids; and

(b) prostheses; and

(c) inhalers, ventilators and oxygen apparatuses; and

(d) crutches, wheelchairs and walking frames;

physical restraint means bodily force that controls a person's freedom of movement;

place, a document on a clinical record, includes causing the document to be placed on the clinical record;

premises includes a part of the premises;

President means the President of the Tribunal;

Principal Official Visitor means the person for the time being holding an appointment under section 155(1);

prison means –

(a) a prison within the meaning of the *Corrections Act 1997*; or

(b) a detention centre within the meaning of the *Youth Justice Act 1997*;

prisoner means –

(a) a prisoner or detainee within the meaning of the *Corrections Act 1997*; or

(b) a person serving a sentence of detention imposed under the *Youth Justice Act 1997* or subject to an order under that Act remanding the person to a detention centre;

privileged caller – see section 98;

privileged correspondent – see section 98;

privileged caller – see section 98;

proper matter includes the objects of this Act, the mental health service delivery principles set out in Schedule 1, MHT guidelines, clinical guidelines and standing orders;

protective custody – see Part 2 of chapter 2;

psychiatrist means a medical practitioner who –

(a) is a Fellow of the Royal Australian and New Zealand College of Psychiatrists; or

(b) holds specialist registration in the specialty of psychiatry; or

(c) holds limited registration that enables the medical practitioner to practise the specialty of psychiatry;

Public Guardian means the Public Guardian under the *Guardianship and Administration Act 1995*;

record includes an electronic record;

Registrar means the Registrar of the Tribunal;

regulations means the regulations made and in force under this Act;

relevant Chief Psychiatrist means according to the context, the Chief Civil Psychiatrist or Chief Forensic Psychiatrist;

representative, of a patient or prospective patient, means –

(a) the patient's guardian; or

(b) the patient's lawyer; or

(c) if the patient is a child and raises no objection, a parent of the patient; or

(d) any other person nominated by the patient to represent his or her interests;

responsibility means a power, function or duty;

restraint means any form of chemical, mechanical or physical restraint;

restriction order means a restriction order made under the *Criminal Justice (Mental Impairment) Act 1999* or *Sentencing Act 1997*;

Secretary (Corrections) means the Secretary of the responsible Department in relation to the *Corrections Act 1997*;

Secretary (Youth Justice) means the Secretary of the responsible Department in relation to the *Youth Justice Act 1997*;

seclusion means the deliberate confinement of an involuntary patient or forensic patient, alone, in a room or area that the patient cannot freely exit;

Secretary means the Secretary of the Department;

secure institution – see section 141;

secure mental health unit means a secure mental health unit approved for this Act under section 140;

sentence of imprisonment includes a sentence of detention imposed under the *Youth Justice Act 1997*;

setting, of any assessment or treatment, means its setting in terms of whether the assessment or treatment occurs or is given in the community or in an approved facility or by some combination thereof;

SMHU means secure mental health unit;

special psychiatric treatment – see section 122(1);

standing orders – see section 152;

State includes Territory;

statement of rights means a written statement that sets out and succinctly explains, in plain language, what rights a patient or prospective patient has in the particular circumstances under this Act in which he or she is required to be given such a statement;

State Servant means a State Service officer or State Service employee;

statutory rule means a statutory rule within the meaning of the *Rules Publication Act 1953*;

supervision order means a supervision order made under the *Criminal Justice (Mental Impairment) Act 1999* or *Sentencing Act 1997*;

support person, of a patient or prospective patient, means a person who provides the patient with ongoing care or support;

treating medical practitioner means the medical practitioner who is responsible for a patient's treatment or proposed treatment;

treatment – see section 6;

treatment criteria means the criteria set out in section 40;

treatment order means a treatment order made under Division 2 of Part 3 of chapter 2, and includes an interim treatment order made under section 38;

Tribunal means the Mental Health Tribunal established under section 167;

urgent circumstances treatment – see section 55 and section 87;

varying, the conditions of any leave, includes adding new conditions and substituting or revoking existing conditions;

voluntary inpatient, of an approved facility, means a person who –

(a) has been admitted to the facility voluntarily to receive treatment for a mental illness; and

(b) is receiving that treatment on the basis of informed consent;

voluntary patient means a person who is not an involuntary patient or a forensic patient;

youth detainee means a person who is –

(a) serving a sentence of detention imposed under the *Youth Justice*

Act 1997 that would, if the person were not a forensic patient, be served in a detention centre; or

(b) subject to an order under the *Youth Justice Act 1997* or another Act remanding the person to a detention centre.

(2) If a provision of this Act requires a document to be in an approved form, the document is to be in a form provided or approved by the person or body indicated in that provision.

(3) A note in the text of this Act does not form part of this Act.

4. Meaning of *mental illness*

(1) For the purposes of this Act –

(a) a person is taken to have a mental illness if he or she experiences, temporarily, repeatedly or continually –

(i) a serious impairment of thought (which may include delusions); or

(ii) a serious impairment of mood, volition, perception or cognition; and

(b) nothing prevents the serious or permanent physiological, biochemical or psychological effects of alcohol use or

drug-taking from being regarded as an indication that a person has a mental illness.

(2) However, under this Act, a person is not to be taken to have a mental illness by reason only of the person's –

(a) current or past expression of, or failure or refusal to express, a particular political opinion or belief; or

(b) current or past expression of, or failure or refusal to express, a particular religious opinion or belief; or

(c) current or past expression of, or failure or refusal to express, a particular philosophy; or

(d) current or past expression of, or failure or refusal to express, a particular sexual preference or orientation; or

(e) current or past engagement in, or failure or refusal to engage in, a particular political or religious activity; or

(f) current or past engagement in a particular sexual activity or sexual promiscuity; or

(g) current or past engagement in illegal conduct; or

(h) current or past engagement in an antisocial activity; or

(i) particular economic or social status; or

(j) membership of a particular cultural or racial group; or

(k) intoxication (however induced); or

(l) intellectual or physical disability; or

(m) acquired brain injury; or

(n) dementia; or

(o) temporary unconsciousness.

5. Meaning of *assessment*

For the purposes of this Act, *assessment* is the clinical process involved in diagnosing the condition of a person's mental health and, where necessary, identifying the most appropriate treatment.

6. Meaning of *treatment*

(1) For the purposes of this Act, *treatment* is the professional intervention necessary to –

(a) prevent or remedy mental illness; or

(b) manage and alleviate, where possible, the ill effects of mental illness; or

(c) reduce the risks that persons with mental illness may, on that account, pose to themselves or others; or

(d) monitor or evaluate a person's mental state.

(2) However, this professional intervention does not extend to –

(a) special psychiatric treatment; or

(b) a termination of pregnancy; or

(c) a procedure that could render a person permanently infertile; or

(d) the removal, for transplantation, of human tissue that cannot thereafter be replaced by natural processes of growth or repair; or

(e) general health care.

7. Capacity of adults and children to make decisions about their own assessment and treatment

(1) For the purposes of this Act, an adult is taken to have the capacity to make a decision about his or her own assessment or treatment (*decision-making capacity*) unless it is established, on the balance of probabilities, that –

(a) he or she is unable to make the decision because of an impairment of, or disturbance in, the functioning of the mind or brain; and

(b) he or she is unable to –

(i) understand information relevant to the decision; or

(ii) retain information relevant to the decision; or

(iii) use or weigh information relevant to the decision; or

(iv) communicate the decision (whether by speech, gesture or other means).

(2) For the purposes of this Act, a child is taken to have the capacity to make a decision about his or her own assessment or treatment (*decision-making capacity*) only if it is established on the balance of probabilities that –

(a) the child is sufficiently mature to make the decision; and

(b) notwithstanding any impairment of, or disturbance in, the functioning of the child's mind or brain, the child is able to –

(i) understand information relevant to the decision; and

(ii) retain information relevant to the decision; and

(iii) use or weigh information relevant to the decision; and

(iv) communicate the decision (whether by speech, gesture or other means).

(3) For the purposes of this section –

(a) an adult or child may be taken to understand information relevant to a decision if it reasonably appears that he or she is able to understand an explanation of the nature and consequences of the decision given in a way that is appropriate to his or her circumstances (whether by words, signs or other means); and

(b) an adult or child may be taken to be able to retain information relevant to a decision even if he or she may only be able to retain the information briefly.

(4) In this section –

information relevant to a decision includes information on the consequences of –

(a) making the decision one way or the other; and

(b) deferring the making of the decision; and

(c) failing to make the decision.

8. Meaning of *informed consent* to assessment or treatment

(1) For the purposes of this Act, a medical practitioner may regard a person's consent to an assessment or a treatment as being informed consent if satisfied that –

(a) the person, at the time of giving the consent, has decision-making capacity; and

(b) the person has had a reasonable opportunity to make a considered decision whether or not to give the consent; and

(c) the person, having had that opportunity, has given the consent freely by some positive means, not by mere acquiescence.

(2) For the purposes of subsection (1)(b) in its application to a treatment, a person may be taken to have had the requisite reasonable opportunity if –

(a) the treating medical practitioner and the person have discussed the treatment; and

(b) in those discussions the person was given an opportunity to disclose his or her priorities, expectations and fears about the treatment; and

(c) following those discussions the person was given –

(i) a clear and candid explanation of the advantages and disadvantages of the treatment, including information about the associated risks and common or expected side effects; and

(ii) where applicable, a clear and candid explanation of the alternative treatments that may be available, including information about the associated advantages and disadvantages; and

(iii) clear and candid answers to any questions the person may have had; and

(iv) any other information that was considered, by the treating medical practitioner or person, to be of relevant importance and likely to influence the person's decision-making with regard to the treatment; and

(v) a reasonable opportunity to –

(A) obtain independent medical or other advice; and

(B) consider the advantages and disadvantages of giving the consent.

(3) For the purposes of subsection (1)(c), a person is taken to have given consent freely if the consent is given without coercion, pressure or undue influence, whether from another person or a medication.

(4) For the purposes of subsection (2), the information, explanations or answers must have been in a language and form that the person could understand.

(5) Nothing in this Act is to be taken to prevent a person with decision-making capacity from withdrawing his or her consent to an assessment or a treatment before the assessment or treatment is made or provided and, if he or she does so, he or she is not to be taken to have given informed consent to the assessment or treatment.

9. Informed consent for child who lacks capacity to decide on own assessment or treatment

(1) For the purposes of this Act, informed consent for the assessment or treatment of a child who lacks decision-making capacity may be given by a parent of the child.

(2) To avoid doubt, for subsection (1) the informed consent of one parent is sufficient.

(3) Informed consent for the assessment or treatment of a child who lacks decision-making capacity may be withdrawn before the assessment or treatment is made or provided, but only by each

parent of the child consenting to the withdrawal of consent.

(4) Nothing in this Act is to be taken to prevent the withdrawal under subsection (3) of consent to an assessment or a treatment before the assessment or treatment is made or provided and, if the consent is withdrawn, informed consent is not to be taken to have been given to the assessment or treatment.

10. Identifying representatives of patients, &c.

(1) Where this Act requires a notice or other document to be given to a representative or support person of a patient, it means that the document is to be given to someone who is, to the knowledge of the person who has to comply with the requirement, such a representative or support person.

(2) For the purposes of subsection (1), the requisite standard of knowledge is knowledge that is already to hand or readily discoverable on reasonable inquiry, not knowledge that might only be discoverable after arduous or prolonged inquiry.

11. Timing of actions

(1) Where this Act requires a person to take an action consequent on some occurrence, then, unless the contrary intention appears, the person

must take that action as soon as practicable after that occurrence.

(2) For the purposes of subsection (1) –

(a) it is irrelevant whether the requirement is mandatory or directory; and

(b) it is irrelevant how the requirement is expressed or described.

PART 3 – OBJECTS, STATUS AND SCOPE OF ACT

12. Objects of Act

The objects of this Act are as follows:

(a) to provide for the assessment, treatment and care of persons with mental illnesses;

(b) to provide for appropriate oversight and safeguards in relation to such assessment, treatment and care;

(c) to give everyone involved with such assessment, treatment and care clear direction as to their rights and responsibilities;

(d) to provide for such assessment, treatment and care to be given in the least restrictive setting consistent with clinical need, legal and judicial constraints, public safety and patient health, safety and welfare;

(e) to promote voluntary over involuntary assessment and treatment and the making of free and informed assessment and treatment choices;

(f) to provide for all incidental and ancillary matters.

13. Status of Act

This Act is intended to be the primary source of authority for the involuntary assessment, treatment and care of persons with mental illness in this State.

14. Act binds Crown

This Act binds the Crown in right of Tasmania and, so far as the legislative power of Parliament permits, in all its other capacities.

CHAPTER 2 – ASSESSMENT, TREATMENT AND MANAGEMENT OF PATIENTS

PART 1 – PRINCIPLES AND POLICIES

15. Mental health service delivery principles

All persons exercising responsibilities under this Act are to have regard to the mental health service delivery principles set out in Schedule 1.

16. Circumstances in which treatment may be given

(1) The following policy governs the treatment of voluntary patients under this Act:

(a) a voluntary patient may be given treatment with informed consent, either as a hospital inpatient or in the community;

(b) a voluntary patient can never be given treatment without informed consent;

(c) a voluntary patient may be given special psychiatric treatment if –

(i) the treatment is authorised by the Tribunal under Part 6; and

(ii) where the treatment is psychosurgery or a treatment that requires informed consent under

that Part, informed consent has been given for the treatment;

(d) a voluntary patient can never be given special psychiatric treatment except as provided by paragraph (c).

(2) The following policy governs the treatment of involuntary patients under this Act who are not forensic patients or involuntary patients to whom section 66 applies:

(a) an involuntary patient may be given treatment –

(i) with informed consent; or

(ii) if the treatment is authorised by a treatment order; or

(iii) if the treatment is urgent circumstances treatment, the treatment is authorised under section 55;

(b) an involuntary patient can never be given treatment except as provided by paragraph (a);

(c) an involuntary patient may be given special psychiatric treatment if –

(i) the special psychiatric treatment is authorised by the Tribunal under Part 6; and

(ii) where the treatment is psychosurgery or a treatment that

requires informed consent under that Part, informed consent has been given for the treatment;

(d) an involuntary patient can never be given special psychiatric treatment except as provided by paragraph (c).

(3) The following policy governs the treatment under this Act of forensic patients or involuntary patients to whom section 66 applies:

(a) a forensic patient, or an involuntary patient to whom section 66 applies, may be given treatment –

(i) with informed consent; or

(ii) if the treatment is authorised by the Tribunal (or a member of the Tribunal) under Division 2 of Part 5; or

(iii) if the patient is also an involuntary patient, if the treatment is authorised by a treatment order; or

(iv) if the treatment is urgent circumstances treatment, if the treatment is authorised under section 87;

(b) a forensic patient, or an involuntary patient to whom section 66 applies, can never be given treatment except as provided by paragraph (a);

(c) a forensic patient, or an involuntary patient to whom section 66 applies, may be given special psychiatric treatment if –

(i) the special psychiatric treatment is authorised by the Tribunal under Part 6; and

(ii) if the treatment is psychosurgery or a treatment that requires informed consent under that Part, informed consent has been given for the treatment;

(d) a forensic patient, or an involuntary patient to whom section 66 applies, can never be given special psychiatric treatment except as provided by paragraph (c).

PART 2 – PROTECTIVE CUSTODY

17. Power to take person into protective custody

(1) An MHO or police officer may take a person into protective custody if the MHO or police officer reasonably believes that –

(a) the person has a mental illness; and

(b) the person should be examined to see if he or she needs to be assessed against the assessment criteria or the treatment criteria; and

(c) the person's safety or the safety of other persons is likely to be at risk if the person is not taken into protective custody.

Note Mental illness has the meaning set out in section 4. The assessment and treatment criteria are set out in section 25 and section 40 respectively.

(2) For the purposes of subsection (1) –

(a) no form of warrant is required; and

(b) the MHO or police officer is not required to confirm whether, under this or any other Act, another process is in train in respect of the person; and

(c) the custody and escort provisions apply, and continue to apply while the person remains in protective custody.

18. Handover of person taken into protective custody

(1) An MHO or police officer who takes a person into protective custody –

(a) must escort the person to an approved assessment centre (or ensure that another MHO or police officer does so); and

(b) may ask any MHO at the approved assessment centre to take over the protective custody of the person.

(2) An MHO who is asked to take over the protective custody of a person pursuant to subsection (1)(b) must comply with the request unless it would be unsafe in the circumstances to do so.

(3) A person's protective custody is not taken to have been interrupted or terminated merely because physical control of the person has been handed over from one MHO or police officer to another such officer.

19. Dealing with person in protective custody

(1) This section applies if a person taken into protective custody has been escorted to an approved assessment centre pursuant to section 18.

(2) The controlling authority of the approved assessment centre must –

(a) give the person a statement of rights in a CCP approved form; and

(b) have the person examined by a medical practitioner, within 4 hours of the person's arrival at the approved assessment centre, to see if the person needs to be assessed against the assessment criteria or the treatment criteria.

20. Release of person from protective custody

(1) An MHO or police officer who has a person in protective custody must release the person from the protective custody if –

(a) before or during the authorised detention period –

(i) informed consent is given to assess or treat the person; or

(ii) an assessment order or treatment order is made in respect of the person; or

(iii) the MHO or police officer reasonably forms the belief that the person no longer meets the criteria for being taken into protective custody, as specified in section 17(1); or

(b) the authorised detention period expires and none of the things referred to in paragraph (a) has occurred.

Note The assessment criteria and the treatment criteria are set out in section 25 and section 40 respectively.

(2) In this section –

authorised detention period means a period, not exceeding 4 hours, calculated from the precise time of the person's arrival at the approved assessment centre.

21. Records, &c.

(1) An MHO or police officer who takes a person into protective custody is to make an appropriate record of the matter in a CCP approved form.

(2) An MHO or police officer, on transferring the protective custody of a person to another such officer, is to hand the record made under subsection (1) (or a copy thereof) to the other officer.

(3) An MHO or police officer who releases a person from protective custody is to –

(a) make an appropriate record of the matter in a CCP approved form; and

(b) give the person a copy of the record, together with the record made under subsection (1) (or a copy thereof); and

(c) give the CCP a copy of the record, together with the record made under subsection (1), after the end of the month in which it is made.

(4) A medical practitioner who examines a person in protective custody is to –

(a) make an appropriate record of the matter in a CCP approved form; and

(b) place a copy of the record on the person's clinical record (ensuring that such a clinical record is created if one does not already exist); and

(c) give the CCP a copy of the record at the end of the month in which it is made.

PART 3 – INVOLUNTARY PATIENTS

Division 1 – Assessment orders

22. Who can make an assessment order?

An assessment order may be made by any medical practitioner.

23. Application for assessment order

(1) Any of the following persons may apply to a medical practitioner for an assessment order:

(a) another medical practitioner;

(b) a nurse;

(c) an MHO;

(d) a police officer;

(e) a guardian, parent or support person of the person (the *prospective patient*) in respect of whom the application is made;

(f) an ambulance officer;

(g) a person prescribed by the regulations.

(2) However, the application should only be made if –

(a) the applicant is satisfied from a personal knowledge of the prospective patient that

the prospective patient has or might have a mental illness; and

(b) the applicant is further satisfied that a reasonable attempt to have the prospective patient assessed, with informed consent, has failed or that it would be futile or inappropriate to make such an attempt.

(3) The application is to be in a CCP approved form and is invalid if not in that form.

24. Determination of application for assessment order

(1) A medical practitioner may make an assessment order in respect of a person in, and only in, the following circumstances:

(a) the medical practitioner must be in receipt of an application for the order;

(b) the medical practitioner, having regard to the requirements of section 23, must be satisfied that –

(i) the applicant is entitled to make the application; and

(ii) the application is in the correct form;

(c) the medical practitioner must have examined the person;

(d) the examination must have been done in the 72-hour period immediately before or after receiving the application;

(e) the medical practitioner must be satisfied from the examination that the person needs to be assessed against the assessment criteria;

(f) the medical practitioner must be satisfied that a reasonable attempt to have the person assessed, with informed consent, has failed or that it would be futile or inappropriate to make such an attempt.

(2) A medical practitioner may make an assessment order requiring a patient's detention in an approved hospital.

(3) Despite subsection (2), a medical practitioner is not to make an assessment order requiring a patient who is a child to be detained in an approved hospital unless the medical practitioner is satisfied that the hospital –

(a) has facilities and staff for the assessment of the patient; and

(b) is, in the circumstances, the most appropriate place to accommodate the patient.

25. Assessment criteria

The assessment criteria are –

(a) the person has, or appears to have, a mental illness that requires or is likely to require treatment for –

(i) the person's health or safety; or

(ii) the safety of other persons; and

(b) 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

(c) the person does not have decision-making capacity.

26. Form and content of assessment order

(1) To be valid, an assessment order must –

(a) be in a CCP approved form; and

(b) be correctly completed.

(2) An assessment order is taken to be correctly completed if it –

(a) identifies the person who applied for it; and

(b) identifies the patient; and

(c) specifies when the examination referred to in section 24(1)(c) was done; and

(d) affirms that (and says how) the patient meets the assessment criteria; and

(e) recommends an assessment setting; and

(f) specifies (by date and time) when it was made; and

(g) specifies or provides for any matter required by the regulations; and

(h) identifies, and is signed by, the medical practitioner who makes it.

(3) An assessment order may, in accordance with section 24(2) and (3), include a requirement that a patient be detained in an approved hospital.

(4) An assessment order may, without compromising its validity, specify or provide for any matters, incidental to the assessment of the person in respect of whom the order is made, that the medical practitioner making it considers necessary or desirable in the circumstances.

27. Effect of assessment order

(1) An assessment order is authority for the patient to be assessed, without informed consent, by an approved medical practitioner, to –

(a) confirm whether the patient meets the assessment criteria; and

(b) determine if the patient also meets the treatment criteria.

(2) However, the assessment order is not authority for the patient to be given any treatment.

28. When does assessment order take effect?

An assessment order takes effect as soon as it is signed by the medical practitioner who makes it.

Note The making of an assessment order is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

29. Action to be taken by medical practitioner on making assessment order

A medical practitioner who makes an assessment order is to –

(a) give a copy of the order to the patient (together with a statement of rights in a CCP approved form); and

(b) give a copy of the order to the approved medical practitioner who is likely to do the assessment or, if applicable, the controlling authority of the approved facility where the patient is to be, or is likely to be, assessed; and

(c) place a copy of the order on the patient's clinical record (ensuring that such a clinical record is created if one does not already exist).

30. Assessment of patient

(1) Once an assessment order has taken effect, the patient must be independently assessed within 24 hours unless the order is sooner discharged.

(2) For the purposes of subsection (1), an assessment is independent if and only if it is done by an approved medical practitioner other than the medical practitioner who applied for or made the assessment order.

Note A failure to observe subsection (1) extinguishes the order – see section 34.

31. Ensuring patient presents for assessment

(1) An assessment order is authority –

(a) for any MHO or police officer to take the patient under escort to ensure that he or she presents for assessment under the order; and

(b) if authorised to do so –

(i) by the terms of the order; or

(ii) by a medical practitioner under subsection (3) –

for the patient to be admitted to an approved facility and, if necessary, detained in an approved hospital for and in connection with that assessment.

(2) For the purposes of subsection (1) –

(a) the medical practitioner who makes the assessment order or any other medical practitioner may request that the patient be taken under escort (in which case the

medical practitioner is to ensure that the escort is given a copy of the order); and

(b) the custody and escort provisions apply, and continue to apply for so long as the patient is subject to the assessment order.

(3) A medical practitioner may authorise for the purposes of subsection (1)(b)(ii) a patient to be admitted to an approved facility or detained in an approved hospital, but may not authorise a patient who is a child to be detained in an approved hospital unless the medical practitioner is satisfied that the hospital –

(a) has facilities and staff for the assessment of the patient; and

(b) is, in the circumstances, the most appropriate place to accommodate the patient.

32. Affirmation or discharge of assessment order

(1) This section applies once a patient who is subject to an assessment order has been independently assessed by an approved medical practitioner.

(2) The approved medical practitioner must immediately affirm or discharge the assessment order.

(3) To affirm the assessment order, the approved medical practitioner must be satisfied that –

(a) the patient meets the assessment criteria; and

(b) the order has not already been discharged.

(4) If the approved medical practitioner affirms the assessment order, he or she may simultaneously extend its operation, once, by a period not exceeding 72 hours commencing from the time of affirmation.

(5) The affirmation is to be effected by means of a signed instrument in writing in a CCP approved form, and is invalid if not in that form.

(6) The instrument of affirmation takes effect as soon as it is signed.

(7) If the approved medical practitioner affirms the assessment order, the procedure in section 33 is to be followed.

(8) If the approved medical practitioner discharges the assessment order, the procedure in section 35(3) and (4) is to be followed.

33. Action to be taken by medical practitioner on affirming assessment order

(1) An approved medical practitioner who affirms an assessment order is to –

(a) give notice to that effect to –

(i) the patient; and

(ii) the medical practitioner who made the order; and

(iii) the CCP; and

(iv) the Tribunal; and

(v) if the patient is to be, or is likely to be, assessed in an approved facility, the controlling authority of the facility; and

(b) place a copy of the instrument of affirmation on the patient's clinical record (ensuring that such a clinical record is created if one does not already exist).

(2) The notice under subsection (1)(a) is to advise of any extension of the operation of the assessment order.

34. Duration of assessment order

An assessment order ceases to have effect –

(a) 24 hours after it takes effect if, by then –

(i) it has not been affirmed under section 32; or

(ii) it has been affirmed under section 32 but not extended in operation under that section; or

(b) if it is affirmed under section 32 and extended in operation under that section, at the end of the period of extension; or

(c) if it is sooner discharged under section 35; or

(d) if a treatment order is made in respect of the person who is subject to the assessment order.

35. Discharge of assessment order by medical practitioner or Tribunal

(1) An assessment order may be discharged at any time for sufficient cause by –

(a) the medical practitioner who made it; or

(b) any approved medical practitioner; or

(c) the Tribunal under section 180.

(2) A medical practitioner has sufficient cause to discharge an assessment order if he or she is satisfied that the patient does not meet the assessment criteria.

(3) In the case of a medical practitioner, the discharge is to be effected by means of a signed instrument in writing in a CCP approved form (the *discharge paper*).

(4) A medical practitioner who discharges an assessment order is to –

(a) give a copy of the discharge paper to –

(i) the patient; and

(ii) the CCP; and

(iii) the Tribunal; and

(iv) if the relevant independent assessment has not been done, the approved medical practitioner who was expected to do the assessment or, if applicable, the controlling authority of the approved facility where the assessment was to have been done; and

(b) place a copy of the discharge paper on the patient's clinical record.

Note For a Tribunal discharge – see Division 2 of Part 3 of chapter 3.

Division 2 – Treatment orders

36. Who can make a treatment order?

Treatment orders are made by the Tribunal.

Note Interim treatment orders, however, may be made by a single member of the Tribunal – see section 38.

37. Application for treatment order

(1) Any approved medical practitioner may apply to the Tribunal for a treatment order in respect of a person.

(2) The application may be made whether or not the person is subject to an assessment order.

(3) If the person is subject to an assessment order, the application should only be made if –

(a) the applicant has assessed the person under the authority of the assessment order; and

(b) the applicant is satisfied from the assessment that the person meets the treatment criteria.

Note The treatment criteria are set out in section 40.

(4) If the person is not subject to an assessment order, the application should only be made if –

(a) the person has been assessed by the applicant and one other approved medical practitioner, separately, within the preceding 7 days; and

(b) the applicant and the other approved medical practitioner are both satisfied from their respective assessments that the person meets the treatment criteria.

(5) The application in relation to a person is to be in accordance with section 195 and be accompanied by –

(a) a statement by the applicant affirming that (and explaining how) the person meets the treatment criteria; and

(b) a proposed treatment plan for the person; and

(c) an indication as to whether an interim treatment order is needed; and

(d) if the person is subject to an assessment order, a copy of that order.

(6) The applicant is to –

(a) give a copy of the application to the person (together with a statement of rights in an MHT approved form); and

(b) place a copy of the application (and accompanying documentation) on the person's clinical record (ensuring that such a clinical record is created if one does not already exist).

38. Interim treatment order

(1) Despite section 36, a single member of the Tribunal may make an interim treatment order in respect of a person if, but only if, the member is satisfied that –

(a) an approved medical practitioner has applied for a treatment order in respect of the person; and

(b) the requirements of section 37 appear to have been met in respect of the application; and

(c) the person meets the treatment criteria; and

(d) the Tribunal cannot immediately determine the application; and

(e) the delay that would be involved in awaiting a decision of the Tribunal under section 39 should the interim treatment order not be made would, or is likely to, seriously harm –

(i) the person's health or safety; or

(ii) the safety of other persons.

(2) An interim treatment order may include a requirement –

(a) that the treatment setting for a patient be –

(i) an approved facility (other than an SMHU), or a premises or place, specified in the order; or

(ii) a type of approved facility (other than an SMHU), or a type of premises or place, specified in the order; and

(b) for the purposes of receiving treatment, a patient be detained in –

(i) an approved facility (other than an SMHU) specified in the order; or

(ii) a type of approved facility (other than an SMHU) specified in the order.

(3) Despite subsection (2), the Tribunal member is not to make an interim treatment order requiring a patient who is a child to be detained in an approved hospital for the purposes of receiving treatment unless the member is satisfied that the hospital –

(a) has facilities and staff for the treatment and care of the patient; and

(b) is, in the circumstances, the most appropriate place available to accommodate the patient.

(4) The Tribunal member may make the interim treatment order on the basis of the application alone, without any hearing or further investigation.

(5) Section 41 applies in relation to the making of an interim treatment order.

(6) If an interim treatment order is made, the order is, for all purposes, taken to be a treatment order made by the Tribunal except that sections 43, 44 and 48 do not apply in relation to the order.

(7) The interim treatment order –

(a) takes effect as soon as it is made; and

(b) continues in effect, subject to subsection (8), until the application is determined by the Tribunal.

(8) Any Tribunal member may revoke or amend the interim treatment order at any time.

(9) The interim treatment order lapses after 10 days (calculated from the precise time it is made) if, by then, the Tribunal has not determined the application.

39. Determination of application for treatment order

(1) The Tribunal may make a treatment order in respect of a person if, and only if, it is satisfied that –

(a) an approved medical practitioner has applied for a treatment order in respect of the person; and

(b) the requirements of section 37 have been met in respect of the application; and

(c) the person meets the treatment criteria.

(2) A treatment order may include a requirement –

(a) that the treatment setting for a patient be –

(i) an approved facility (other than an SMHU), or a premises or place, specified in the order; or

(ii) a type of approved facility (other than an SMHU), or a type of premises or place, specified in the order; and

(b) that, for the purposes of receiving treatment, a patient be detained in –

(i) an approved facility (other than an SMHU) specified in the order; or

(ii) a type of approved facility (other than an SMHU) specified in the order.

(3) Despite subsection (2), the Tribunal is not to make a treatment order requiring a patient who is a child to be detained in an approved hospital for the purposes of receiving treatment unless it is satisfied that the hospital –

(a) has facilities and staff for the treatment and care of the patient; and

(b) is, in the circumstances, the most appropriate place available to accommodate the patient.

(4) The Tribunal is to determine an application for a treatment order as soon as practicable after it is received and must do so by way of a hearing.

(5) An application for a treatment order lapses and is rendered invalid if the Tribunal for any reason fails to determine the application within 10 days after it is lodged.

(6) The President of the Tribunal is to ensure that a hearing for the purposes of this section is before a division of the Tribunal constituted by 3 members.

40. Treatment criteria

The treatment criteria in relation to a person are –

(a) the person has a mental illness; and

(b) without treatment, the mental illness will, or is likely to, seriously harm –

(i) the person's health or safety; or

(ii) the safety of other persons; and

(c) the treatment will be appropriate and effective in terms of the outcomes referred to in section 6(1); and

(d) the treatment cannot be adequately given except under a treatment order; and

(e) the person does not have decision-making capacity.

41. Form and content of treatment order

(1) To be valid, a treatment order must –

(a) be in an MHT approved form; and

(b) be correctly completed.

(2) A treatment order is taken to be correctly completed if it –

(a) identifies the approved medical practitioner who applied for it; and

(b) identifies the person who is subject to the order; and

(c) specifies the treatment, or types of treatment, authorised under the order; and

(d) specifies –

(i) the treatment plan for the person; and

(ii) that the treatment, and treatment setting, under the order are to be in accordance with the treatment plan, including such a plan varied under section 54; and

(e) specifies (by date and time) when it was made; and

(f) specifies the maximum period it is expected to remain in effect (if not sooner discharged); and

(g) specifies or provides for any matters required by the regulations.

(3) A treatment order may, in accordance with section 39(2) and (3) or, in the case of an interim treatment order, in accordance with section 38(2) and (3), include a requirement in relation to treatment settings and detention.

(4) If an assessment order in respect of a person is, under section 34(d), discharged by the making of a treatment order or an interim treatment order, the Tribunal may specify in the treatment order that the assessment order has been so discharged.

(5) A treatment order may, without compromising its validity, specify or provide for any other matters, incidental to the treatment of the person in respect of whom the order is made, that the Tribunal considers necessary or desirable in the circumstances.

42. Effect of treatment order

(1) A treatment order is authority for the patient, without informed consent –

(a) to be given the treatment specified in the order and referred to in the treatment plan for the patient, as varied, if at all, under section 54; or

(b) if a type of treatment is specified in the order, to be given treatment of that type that is specified in the treatment plan for

the patient, as varied, if at all, under section 54.

(2) A treatment order is –

(a) if an approved facility is specified in the order and referred to in the treatment plan for the patient (as varied, if at all, under section 54), authority for the patient, without informed consent, to be admitted to, and detained in, that approved facility for the purposes of receiving treatment; or

(b) if a type of approved facility is specified in the order and specified in the treatment plan for the patient (as varied, if at all, under section 54), authority for the patient, without informed consent, to be admitted to, and detained in, such an approved facility for the purposes of receiving treatment; or

(c) in any case, if section 47 applies in relation to the patient, authority for the patient to be detained in an approved facility (other than an SMHU) –

until whichever of the following first occurs:

(d) the patient is discharged;

(e) the order is varied so as to provide for a different treatment setting;

(f) if the detention is authorised under the order, the order ceases to have effect under this Act.

(3) If a patient is admitted to an approved facility under this section, the controlling authority of the approved facility is to notify the Tribunal and the CCP of the patient's admission.

43. When does treatment order take effect?

A treatment order takes effect as soon as it is made.

44. Duration of treatment order

A treatment order, unless sooner discharged under section 49 or section 181, continues in effect for such period not exceeding 6 months (calculated from the precise time it is made) as the Tribunal specifies in the order.

45. Action to be taken by Tribunal on making treatment order

On making a treatment order, the Tribunal is to –

(a) give the patient notice to that effect and a copy of the order (together with a statement of rights in an MHT approved form); and

(b) give notice to that effect and a copy of the order to –

(i) the approved medical practitioner who applied for the order; and

(ii) the treating medical practitioner; and

(iii) if the patient is in, or is expected to be in, an approved facility, the controlling authority of that facility; and

(iv) the CCP.

46. Ensuring patient presents for treatment, &c.

(1) A treatment order in respect of a person is authority for any MHO or police officer to take the patient under escort to ensure that he or she presents for treatment under the order.

(2) For the purposes of subsection (1) –

(a) the Tribunal, any member of the Tribunal, the Registrar, the CCP or any medical practitioner may request that the patient be taken under escort (in which case the maker of the request is to give the escort a copy of the treatment order); and

(b) the custody and escort provisions apply, and continue to apply for so long as the patient is subject to the treatment order.

47. Failure to comply with treatment order

(1) This section applies if –

(a) a patient is subject to a treatment order; and

(b) reasonable steps have been taken to obtain the patient's compliance with the order; and

(c) the treating medical practitioner is satisfied on reasonable grounds that –

(i) despite those reasonable steps, the patient has failed to comply with the treatment order; and

(ii) the failure in compliance has seriously harmed, or is likely to seriously harm –

(A) the patient's health or safety; or

(B) the safety of other persons; and

(iii) the harm or likely harm cannot be adequately addressed except by way of an alternative treatment or treatment setting (being a treatment or treatment setting that is inconsistent with the treatment order).

(2) If this section applies, the treating medical practitioner may, according to the circumstances –

(a) apply to the Tribunal, under Division 2 of Part 3 of chapter 3, to vary the treatment order; or

(b) seek to have the patient taken under escort under section 46 and involuntarily admitted to an approved facility under and in accordance with section 42; or

(c) apply to the CCP, under section 55(3), for authorisation to give the patient urgent circumstances treatment.

(3) However, the treating medical practitioner is not, by any of the processes referred to in subsection (2), to seek to have a patient who is a child detained in an approved hospital unless the treating medical practitioner is satisfied that the hospital –

(a) has facilities and staff for the treatment and care of the patient; and

(b) is, in the circumstances, the most appropriate place to accommodate the patient.

48. Renewal of treatment order

(1) The Tribunal may renew a treatment order on the application of any approved medical practitioner (the *applicant*).

(2) An application must be made at least 10 days before the day during which the treatment order is due to expire, and is invalid if it is not.

(3) An application is to be in accordance with section 195 and be accompanied by –

(a) a copy of the treatment order; and

(b) particulars of any recommended change in treatment or to the treatment setting; and

(c) a statement by the applicant affirming that (and explaining how) the patient continues to meet the treatment criteria and is expected to continue to meet those criteria for the period of renewal.

(4) An applicant for the renewal of a treatment order –

(a) is to give a copy of the application to the patient (together with a statement of rights in an MHT approved form); and

(b) is –

(i) to give a copy of the application to the treating medical practitioner (if it is someone other than the applicant); and

(ii) to give a copy of the application to the CCP; and

(iii) if the patient is in, or is expected to be in, an approved facility, to

give a copy of the application to the controlling authority of that facility; and

(c) is to place a copy of the application (and accompanying documentation) on the patient's clinical record.

(5) The Tribunal is to determine an application as soon as practicable after it is made and must do so by way of a hearing.

(6) To avoid doubt, a treatment order may only be renewed if it is still in effect.

(7) A treatment order in respect of a person may only be renewed if the Tribunal is satisfied that –

(a) the applicant has complied with subsection (4); and

(b) the person meets the treatment criteria.

(8) Under this section, a treatment order may be renewed for –

(a) if it has not previously been renewed, a period not exceeding 6 months; or

(b) in any other case, a period not exceeding 12 months.

(9) On renewing a treatment order, the Tribunal is to –

(a) give notice of the renewal to the patient (together with a statement of rights in an MHT approved form); and

(b) give notice of the renewal to –

(i) the applicant; and

(ii) the treating medical practitioner (if it is someone other than the applicant); and

(iii) if the patient is in, or is expected to be in, an approved facility, the controlling authority of that facility; and

(iv) the CCP.

(10) A notice under subsection (9) is to specify the period of renewal.

49. Discharge of treatment order by medical practitioner or Tribunal

(1) A treatment order may be discharged by –

(a) any approved medical practitioner under this section; or

(b) the Tribunal under section 181.

(2) An approved medical practitioner must discharge a treatment order if satisfied, after assessing the patient while the order is in effect, that the patient does not meet the treatment criteria.

(3) However, unless the approved medical practitioner is also the treating medical

practitioner, the discharge may only be effected if –

(a) the approved medical practitioner has consulted the treating medical practitioner; and

(b) the treating medical practitioner agrees that the patient does not meet the treatment criteria.

(4) The discharge is to be effected by the approved medical practitioner by means of a signed instrument in writing in an MHT approved form (the *discharge paper*).

(5) On signing the discharge paper, the approved medical practitioner is to –

(a) give a copy of the discharge paper to –

(i) the patient; and

(ii) if applicable, the treating medical practitioner; and

(iii) the CCP; and

(iv) the Tribunal; and

(b) place a copy of the discharge paper on the patient's clinical record.

Note For a Tribunal discharge – see Division 2 of Part 3 of chapter 3.

Division 3 – Treatment plans

50. Nature of treatment plan

The treatment plan for a patient is an instrument that sets out an outline of the treatment the patient is to receive.

51. Requirement for treatment plan

The CCP is to ensure that each involuntary patient has a treatment plan.

52. Form of treatment plan

(1) A treatment plan is to be in a CCP approved form.

(2) However, a treatment plan that is not in a CCP approved form is not, on that account, invalid.

53. Preparation of treatment plan

(1) A patient's treatment plan may be prepared by any medical practitioner involved in the patient's treatment or care.

(2) In preparing a treatment plan, a medical practitioner –

(a) is to consult the patient; and

(b) may, after consulting the patient, consult such other persons as the medical practitioner thinks fit in the circumstances.

(3) A medical practitioner who prepares a treatment plan is to –

(a) give a copy of the treatment plan to –

(i) the patient; and

(ii) the CCP; and

(b) place a copy of the treatment plan on the patient's clinical record.

54. Variation of treatment plan

(1) A patient's treatment plan may be varied at any time by any medical practitioner involved in the patient's treatment or care.

(2) The treatment plan for a patient subject to a treatment order may only be varied under subsection (1) if the treatment plan, as so varied, is in accordance with, and is not more restrictive of the patient's rights, privileges and freedom of action than, the treatment order.

(3) In varying a treatment plan, a medical practitioner –

(a) is to consult the patient; and

(b) may, after consulting the patient, consult such other persons as the medical practitioner thinks fit in the circumstances.

(4) A medical practitioner who varies a treatment plan is to –

(a) ensure that the variation (and the reason for the variation) is fully documented; and

(b) give a copy of the documentation to the CCP; and

(c) give a copy of the documentation to the Tribunal; and

(d) place a copy of the documentation on the patient's clinical record; and

(e) give notice of the variation (and the reason for the variation) to the patient.

(5) The notice to the patient may contain such further particulars as the medical practitioner thinks fit in the circumstances.

Division 4 – Urgent circumstances treatment

55. Urgent circumstances treatment

(1) An involuntary patient may be given treatment (*urgent circumstances treatment*) without informed consent or Tribunal authorisation if the

CCP authorises the treatment as being urgently needed in the patient's best interests.

(2) The CCP may, under subsection (1), authorise treatment as being urgently needed in the patient's best interests only if the CCP is of the opinion that achieving the necessary treatment outcome would be compromised by waiting for the urgent circumstances treatment to be authorised by the Tribunal (or by a member thereof on an interim basis).

(3) The authorisation may be given on the application of any medical practitioner involved in the patient's treatment or care (the *applicant*).

(4) The application may be made by any means acceptable to the CCP in the circumstances.

(5) The CCP may give the authorisation if, and only if –

(a) an approved medical practitioner has concluded from an assessment that –

(i) the patient has a mental illness that is generally in need of treatment; and

(ii) the urgent circumstances treatment is necessary for –

(A) the patient's health or safety; or

(B) the safety of other persons; and

(iii) the urgent circumstances treatment is likely to be effective and appropriate in terms of the outcomes referred to in section 6(1); and

(iv) achieving the necessary treatment outcome would be compromised by waiting for the urgent circumstances treatment to be authorised by the Tribunal (or by a member thereof on an interim basis); and

(b) the CCP agrees with the approved medical practitioner's conclusion; and

(c) the CCP is satisfied that a reasonable attempt to give the patient the urgent circumstances treatment with informed consent has failed or that it would be futile or inappropriate to make such an attempt.

(6) If the authorisation is given, the CCP is to advise the following persons of the authorisation without delay:

(a) the applicant;

(b) the approved medical practitioner (if it is someone other than the applicant);

(c) the Tribunal.

(7) The advice under subsection (6) may be given by any means of communication the CCP considers

appropriate in the circumstances but, if it is given orally, the CCP is to confirm it in writing by means of a CCP approved form.

(8) If the authorisation is given, the applicant has the following obligations:

(a) to give a copy of the authorisation to the patient (together with a statement of rights in a CCP approved form);

(b) to place a copy of the authorisation on the patient's clinical record.

(9) If the authorisation is given, the patient may be given the urgent circumstances treatment until whichever of the following first occurs:

(a) the treatment is completed;

(b) the CCP, for any reason he or she considers sufficient, revokes the authorisation;

(c) an approved medical practitioner, for any reason he or she considers sufficient, stops the treatment;

(d) the 96-hour period immediately following the giving of the authorisation expires;

(e) the authorisation is set aside by the Tribunal.

(10) To avoid doubt, and without limiting the generality of section 149, in this section –

CCP includes a delegate of the CCP.

Note 1 This section does not limit or otherwise affect the operation of section 40 of the *Guardianship and Administration Act 1995*.

Note 2 The authorisation of urgent circumstances treatment is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

Division 5 – Seclusion and restraint

56. Seclusion

(1) Except if authorised under any other law, an involuntary patient who is not a forensic patient may be placed in seclusion if, and only if –

(a) the patient is in an approved hospital; and

(b) the seclusion is authorised as being necessary for a prescribed reason, by –

(i) for a patient who is a child, the CCP; or

(ii) for any other patient, the CCP, a medical practitioner or approved nurse; and

(c) the person authorising the seclusion is satisfied that it is a reasonable intervention in the circumstances; and

(d) the seclusion lasts for no longer than authorised under this section; and

(e) the seclusion is managed in accordance with any relevant CCP standing orders or clinical guidelines.

(2) If an involuntary patient who is not a forensic patient is placed in seclusion under this section –

(a) the patient must be clinically observed by a member of the approved hospital's nursing staff at intervals not exceeding 15 minutes or at such different intervals as CCP standing orders may mandate; and

(b) the patient must be examined by a medical practitioner or approved nurse at intervals not exceeding 4 hours to see if the seclusion should continue or be terminated; and

(c) the patient must also be examined by an approved medical practitioner at intervals not exceeding 12 hours; and

(d) the seclusion must not extend beyond 7 hours unless –

(i) the patient has been examined by a medical practitioner within those 7 hours; and

(ii) the extension is authorised by the CCP within those 7 hours; and

(iii) if applicable, each subsequent extension (regardless of duration)

is also authorised in advance by the CCP; and

(e) the CCP may impose conditions on any extension authorised under paragraph (d); and

(f) the CCP, on authorising an initial extension of the seclusion, must stipulate the maximum timeframe for its continuance; and

(g) the patient must be provided with –

(i) suitable clean clothing and bedding; and

(ii) adequate sustenance; and

(iii) adequate toilet and sanitary arrangements; and

(iv) adequate ventilation and light; and

(v) a means of summoning aid; and

(h) the administration of any prescribed medications to the patient must not be unreasonably denied or delayed; and

(i) the patient must not be deprived of physical aids except as may be strictly necessary for the patient's safety or the preservation of those physical aids for the patient's future use; and

(j) regardless of authorisation, the seclusion must not be maintained to the obvious detriment of the patient's mental or physical health.

(3) To avoid doubt, an involuntary patient's seclusion is not taken to have been interrupted or terminated merely by reason of –

(a) a scheduled observation or examination under subsection (2); or

(b) the giving of any necessary treatment or general health care.

(4) Nothing in this section is to be taken as conferring any kind of authority for a patient to be placed in seclusion as a means of punishment or for reasons of mere administrative or staff convenience.

(5) In this section –

prescribed reason, for placing a patient in seclusion, means –

(a) to facilitate the patient's treatment; or

(b) to ensure the patient's health or safety; or

(c) to ensure the safety of other persons; or

(d) to provide for the management, good order or security of an approved hospital.

Note 1 The seclusion of an involuntary patient is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

Note 2 The CCP has power to intervene in such circumstances – see section 147.

57. Restraint

(1) Except if authorised under any other law, an involuntary patient who is not a forensic patient may be placed under restraint if, and only if –

(a) the patient is in an approved assessment centre or approved hospital; and

(b) the restraint is authorised as being necessary for a prescribed reason by –

(i) in the case of chemical or mechanical restraint, the CCP; or

(ii) in the case of physical restraint where the patient is a child, the CCP; or

(iii) in the case of physical restraint where the patient is not a child, the CCP, a medical practitioner or an approved nurse; and

(c) the person authorising the restraint is satisfied that it is a reasonable intervention in the circumstances; and

(d) the restraint lasts for no longer than authorised under this section; and

(e) the means of restraint employed in the specific case is, in the case of a

mechanical restraint, approved in advance by the CCP; and

(f) the restraint is managed in accordance with any relevant CCP standing orders or clinical guidelines.

(2) If an involuntary patient who is not a forensic patient is placed under restraint under this section –

(a) the patient must be clinically observed by a member of the approved hospital's nursing staff at intervals not exceeding 15 minutes or at such different intervals as CCP standing orders may mandate; and

(b) the patient must be examined by a medical practitioner or approved nurse at intervals not exceeding 4 hours to see if the restraint should continue or be terminated; and

(c) the patient must also be examined by an approved medical practitioner at intervals, each of not more than 12 hours; and

(d) the restraint must not be applied beyond 7 hours unless –

(i) the patient has been examined by a medical practitioner within those 7 hours; and

(ii) the extension is authorised by the CCP within those 7 hours; and

(iii) if applicable, each subsequent extension (regardless of duration) is also authorised in advance by the CCP; and

(e) the CCP may impose conditions on any extension authorised under paragraph (d); and

(f) the CCP, on authorising an initial extension of the restraint, must stipulate the maximum timeframe for its continuance; and

(g) the patient must be provided with –

(i) suitable clean clothing and bedding; and

(ii) adequate sustenance; and

(iii) adequate toilet and sanitary arrangements; and

(iv) adequate ventilation and light; and

(v) a means of summoning aid; and

(h) the administration of any prescribed medications to the patient must not be unreasonably denied or delayed; and

(i) the patient must not be deprived of physical aids except as may be strictly

necessary for the patient's safety or the preservation of those physical aids for the patient's future use; and

(j) regardless of authorisation, the restraint must not be maintained to the obvious detriment of the patient's mental or physical health.

(3) Nothing in this section is to be taken as conferring any kind of authority for a patient to be placed under restraint as a means of punishment or for reasons of administrative or staff convenience.

(4) However, nothing in this section applies to or prevents the emergency short-term physical restraint of a patient, subject to and in accordance with relevant CCP standing orders or clinical guidelines, so as to –

(a) prevent the patient from harming himself or herself or others; or

(b) prevent the patient from damaging, or interfering with the operation of, a facility or any equipment; or

(c) break up a dispute or affray involving the patient; or

(d) ensure, if he or she is uncooperative, the patient's movement to or attendance at any place for a lawful purpose.

(5) Notwithstanding the discretionary nature of the power under section 152(1), the CCP must

ensure that standing orders are issued for this section.

(6) In this section –

prescribed reason, for placing a patient under restraint, means –

(a) to facilitate the patient's treatment; or

(b) to ensure the patient's health or safety; or

(c) to ensure the safety of other persons; or

(d) to effect the patient's transfer to another facility, whether in this State or elsewhere.

Note 1 The restraint of an involuntary patient is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

Note 2 The CCP has power to intervene in such circumstances – see section 147.

58. Records, &c.

(1) This section applies if an involuntary patient who is not a forensic patient is placed in seclusion or under restraint under this Part.

(2) The person who authorises the seclusion or restraint is to –

(a) make an appropriate record of the matter; and

(b) give a copy of the record to the CCP and the Tribunal; and

(c) place a copy of the record on the patient's clinical record.

(3) The CCP or Tribunal, by notice, may require the treating medical practitioner to provide further information about the matter within a required time and the treating medical practitioner is to comply with that requirement.

Division 6 – Patient movements in respect of approved hospitals

59. Transfer of involuntary patients between approved hospitals

(1) The CCP may direct that an involuntary patient be transferred from one approved hospital to another if satisfied that the transfer is necessary for –

(a) the patient's health or safety; or

(b) the safety of other persons.

(2) The direction (the *transfer direction*) is to be in a CCP approved form, specifying the mode and conditions of transport, and is invalid if not in that form.

(3) The CCP is to –

(a) give a copy of the transfer direction to the patient (together with a statement of rights in a CCP approved form); and

(b) give a copy of the transfer direction to –

(i) the controlling authority of each hospital; and

(ii) the treating medical practitioner; and

(iii) the Tribunal; and

(c) place a copy of the transfer direction on the patient's clinical record.

(4) The CCP is to ensure that, if practicable, the actions required by subsection (3)(a) and (b) are taken before the transfer takes place.

(5) The transfer direction is authority for an MHO to –

(a) take the patient under escort; and

(b) remove the patient from the transferring hospital; and

(c) take the patient to the other hospital.

(6) For the purposes of subsection (5) –

(a) the CCP may request that the patient be taken under escort (in which case the CCP is to ensure that the escort is given a copy of the transfer direction); and

(b) the custody and escort provisions apply.

(7) Once the patient has been transferred, an order for the involuntary admission, or detention, of the patient in the transferring hospital has effect as if it provided for the involuntary admission or detention of the patient in the other hospital.

Note The transfer of an involuntary patient under this section is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

60. Leave of absence from approved hospital

(1) An approved medical practitioner may grant an involuntary patient leave of absence from an approved hospital (*leave*).

(2) The leave may be granted for clinical or personal reasons, and for any period not exceeding 14 days.

(3) Leave for personal reasons may be granted only on the application of –

(a) the patient; or

(b) a person who, in the opinion of the approved medical practitioner, has a genuine interest in the patient's welfare.

(4) The patient may ask any staff member of the approved hospital for help in making the request and the staff member is to –

(a) render that help to the best of his or her ability; or

(b) arrange for another staff member of the approved hospital to render that help.

(5) The leave is to be granted by means of an instrument in writing (the *leave pass*).

(6) The leave may be granted on such conditions as the approved medical practitioner considers necessary or desirable for the patient's health or safety or the safety of other persons.

(7) Without limiting the generality of subsection (6), the patient may be required to be under escort during the leave or any portion thereof (in which case the custody and escort provisions apply).

(8) The approved medical practitioner is to ensure that the conditions are specified in the leave pass.

(9) Depending on when the leave is to be taken, the approved medical practitioner is to –

(a) give a copy of the leave pass to the patient in good time (together with a statement of rights in a CCP approved form); and

(b) give a copy of the leave pass in good time to –

(i) the controlling authority of the relevant approved hospital; and

(ii) if applicable, the patient's escort; and

(iii) the Tribunal; and

(iv) the CCP; and

(c) place a copy of the leave pass on the patient's clinical record.

(10) Any approved medical practitioner may at any time, by notice to the patient –

(a) extend the leave (but not so as to let the total period of leave exceed 14 days); or

(b) vary the conditions of the leave; or

(c) cancel the leave.

(11) To avoid doubt –

(a) the power under subsection (10)(a) may be exercised more than once (but not so as to let the total period of leave exceed 14 days); and

(b) the power under subsection (10)(b) may be exercised more than once; and

(c) a notice under subsection (10) may be expressed to take immediate or deferred effect.

(12) On issuing a notice under subsection (10), an approved medical practitioner is to –

(a) give a copy of the notice to –

(i) the controlling authority of the relevant approved hospital; and

(ii) if applicable, the patient's escort; and

(iii) the Tribunal; and

(iv) the CCP; and

(b) place a copy of the notice on the patient's clinical record.

(13) An approved medical practitioner who refuses an application for leave under this section is to –

(a) give notice of the refusal, with reasons, to the applicant (together with a statement of rights in a CCP approved form); and

(b) if the applicant was someone other than the patient, give notice of the refusal, with reasons, to the patient (together with a statement of rights in a CCP approved form); and

(c) place a copy of the notice of refusal, with reasons, on the patient's clinical record.

Note 1 A leave of absence under this section is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3. The power of review extends to every facet of such leave including refusal, cancellation and variation.

Note 2 The CCP has power to intervene in such circumstances – see section 147.

61. Failure to comply with condition of leave of absence from approved hospital

(1) This section applies if –

(a) an involuntary patient has taken leave of absence from an approved hospital pursuant to section 60; and

(b) any of the following occurs:

(i) the patient fails to comply with a condition of the leave;

(ii) the leave is cancelled;

(iii) the period of leave expires and the patient has not returned to the approved hospital; and

(c) the order authorising the patient's detention in the approved hospital is still in effect.

(2) The treating medical practitioner may alert the Commissioner of Police of the circumstances.

(3) Any MHO or police officer may take the patient into protective custody and return the patient to the approved hospital.

(4) For the purposes of subsection (3), the custody and escort provisions apply.

Division 7 – Patient rights

62. Rights of involuntary patients

Every involuntary patient has the following rights:

(a) the right to have the restrictions on, and interference with, his or her dignity, rights and freedoms kept to a minimum consistent with his or her health or safety and the safety of other persons;

(b) the right to have his or her decision-making capacity promoted, and his or her wishes respected, to the maximum extent consistent with his or her health or safety and the safety of other persons;

(c) the right, while in an approved hospital, to have access to current information about local, national and world events;

(d) the right to be given clear, accurate and timely information about –

(i) his or her rights as an involuntary patient; and

(ii) the rules and conditions governing his or her conduct in the hospital; and

(iii) his or her diagnosis and treatment;

(e) the right, while in an approved hospital, to apply for leave of absence in accordance with this Act;

(f) the right to have contact with, and to correspond privately with, his or her representatives and support persons and with Official Visitors;

(g) the right, while in an approved hospital, to be provided with general health care;

(h) the right, while in an approved hospital, to wear his or her own clothing (where appropriate to the treatment setting);

(i) the right, while in an approved hospital, not to be unreasonably deprived of any necessary physical aids;

(j) the right, while in an approved hospital, to be detained in a manner befitting his or her assessment, treatment or care requirements;

(k) the right, while in an approved hospital, to practise a religion of the patient's choice, to join with other patients in practising that religion and to possess such articles as are reasonably necessary for the practice of that religion (to such extent as is consistent with his or her health or safety, the safety of other persons and the management, good order and security of the hospital);

(l) the right, while in an approved hospital –

(i) to practise customs in accordance with the patient's cultural beliefs or cultural background; and

(ii) to join with other patients in practising those customs; and

(iii) to possess articles that are reasonably necessary for the practice of those customs –

to the extent that the practice of those customs is not contrary to any law and is consistent with the health and safety of the patient and other patients and the management, good order and security of the hospital;

(m) the right, while in an approved hospital, to ask for and be given such reasonable help from hospital staff as will enable the patient to enjoy these rights.

Division 8 – Admission of involuntary patients to SMHU

63. Admission

(1) An involuntary patient who is not a person to whom section 68(1) applies may be admitted to an SMHU if the admission is authorised by the CFP.

Note An involuntary patient who is a person to whom section 68(1) applies may be admitted to an SMHU under section 68.

(2) However, such authorisation may be given only if –

(a) the patient is being detained in an approved hospital; and

(b) the patient is not a prisoner or youth detainee; and

(c) the CCP has formally requested the CFP to give the authorisation; and

(d) the CFP is satisfied that –

(i) the patient is, by reason of mental illness, a danger to himself or herself or to others; and

(ii) that danger is or has become so serious as to make the patient's continued detention in the approved hospital untenable; and

(iii) in the circumstances, an SMHU is the only appropriate place where the patient can be safely detained; and

(iv) the particular SMHU has the resources to give the person appropriate treatment and care; and

(e) if the patient is a child, the CFP is further satisfied that –

(i) the patient can be detained separately from adults; and

(ii) the probable benefits of accommodating the patient in an SMHU outweigh the probable risks.

(3) A patient admitted to an SMHU under this section may still be treated under the authority of a subsisting treatment order.

64. Admissions procedure, extensions and transfer

(1) On authorising the admission of an involuntary patient to an SMHU under section 63, the CFP is to –

(a) determine the period for which the patient may be detained in the SMHU (the *period of detention*); and

(b) give notice of the admission, the reasons for the admission and the period of detention to the patient (together with a statement of rights, relating to the patient's rights under Part 4 and Part 5, in a CFP approved form); and

(c) give notice of the admission and the period of detention to –

(i) the controlling authority of the SMHU; and

(ii) the controlling authority of the approved hospital from which the patient is being transferred; and

(iii) the CCP; and

(iv) the Tribunal.

(2) The CFP may extend the period of detention and, to avoid doubt, may do so more than once.

(3) Before determining or extending the period of detention, the CFP is to consult the CCP.

(4) On extending the period of detention, the CFP is to –

(a) give notice of the extension, and the reasons for it, to the patient (together with a statement of rights in a CFP approved form); and

(b) give notice of the extension to –

(i) the controlling authority of the SMHU; and

(ii) the controlling authority of the approved hospital from which the patient was transferred; and

(iii) the CCP; and

(iv) the Tribunal.

(5) If at any time the CFP is satisfied that the patient no longer meets the requirements of admission, the CFP is to request the CCP to arrange for the patient to be transferred to an approved hospital.

(6) The transfer request is to be in a CFP approved form.

(7) The CCP is to –

(a) accede to the transfer request; and

(b) notify the CFP when the patient has been transferred.

(8) To effect the transfer, an authorised person may –

(a) take the patient under escort; and

(b) remove the patient from the SMHU; and

(c) take the patient to an approved hospital.

(9) For the purposes of subsection (8), the custody and escort provisions apply.

Note The admission of an involuntary patient to an SMHU under this Subdivision (and any extension of the period of detention) is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

65. Period of detention

Subject to any orders of the Tribunal, an involuntary patient admitted to an SMHU under section 63 may be detained there until –

(a) the end of the period of detention determined under section 64(1) (or as extended under section 64(2)); or

(b) if the CFP makes a request under section 64(5), the end of the 24-hour period after the request is made.

66. Admitted involuntary patient to be treated as forensic patient for certain purposes

(1) The relevant provisions of this Act apply to a patient who –

(a) is admitted to an SMHU under section 63; and

(b) who has not been discharged or transferred to an approved hospital under section 64(5) –

as if he or she were a forensic patient who is not subject to a restriction order.

(2) For the purposes of subsection (1), the relevant provisions are –

(a) the provisions of Part 4 (other than Division 1), as modified in accordance with section 67; and

(b) the provisions of Part 5, other than section 88, section 91, section 119 and section 120; and

(c) sections 188, 190, 191 and 192; and

(d) Chapter 4.

(3) Divisions 4, 5, 6 and 7 do not apply to a person to whom subsection (1) applies.

67. Leave of absence for involuntary SMHU patient

In its application, by virtue of section 66, to an involuntary patient, Division 6 of Part 4 is modified as follows:

(a) the CCP is an interested person for the purposes of that Division;

(b) the Commissioner of Police, Secretary (Corrections), Director and Secretary (Youth Justice) are not interested persons for the purposes of that Division;

(c) section 82(7), (8) and (9) do not apply;

(d) section 83(2) does not apply.

Note Division 6 of Part 4 relates to leave of absence by forensic patients. Section 66 makes such provisions apply to involuntary patients. A leave of absence under this section is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3. The power of review extends to every facet of such leave, including refusal, cancellation and variation.

PART 4 – ADMISSION AND CUSTODY OF FORENSIC PATIENTS

Division 1 – Admission of forensic patients to SMHU

68. Admission

(1) This section applies to a person who –

(a) is subject to a restriction order; or

(b) being subject to a supervision order, is apprehended under section 31 of the *Criminal Justice (Mental Impairment) Act 1999*; or

(c) is subject to an order under section 39(1)(b)(ii) of the *Criminal Justice (Mental Impairment) Act 1999*; or

(d) is subject to an order referred to in section 73 of the *Sentencing Act 1997* providing or allowing for the person's admission to and detention in an SMHU; or

(e) is subject to an order under section 47 of the *Justices Act 1959* committing the person to an SMHU; or

(f) is subject to an order under section 348 of the *Criminal Code* committing the person to an SMHU; or

(g) is subject to an order under section 105 of the *Youth Justice Act 1997* remanding the person to an SMHU; or

(h) is subject to any other order of a court under the *Criminal Justice (Mental Impairment) Act 1999*, *Criminal Code Act 1924*, *Justices Act 1959*, *Sentencing Act 1997* or *Youth Justice Act 1997* remanding or committing the person to or in, or otherwise requiring the person to be detained in, an SMHU; or

(i) if the person is a prisoner (but not a detainee under the *Youth Justice Act 1997*), the person's removal from a prison to an SMHU is directed under section 36A(2) or (3) of the *Corrections Act 1997*; or

(j) if the person is a detainee under the *Youth Justice Act 1997*, the person's removal from a detention centre to an SMHU is directed under section 134A(2) or (3) of that Act.

(2) A person to whom this section applies may be admitted to an SMHU.

(3) A person who is admitted to an SMHU under subsection (2) is a forensic patient for the purposes of this Act.

Note The admission to an SMHU of a person referred to in subsection (1)(i) or (j) is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

69. Period of detention

A forensic patient may be detained in an SMHU until –

(a) if the patient is subject to a restriction order, the order is discharged; or

(b) if the patient is subject to a supervision order, the end of the period allowed under section 31(6), (7) or (8) of the *Criminal Justice (Mental Impairment) Act 1999*; or

(c) if the patient is subject to an order referred to in section 68(1)(c), (d), (e), (f), (g) or (h), the order ends under its own terms or under the provisions of any Act; or

(d) if the patient is a prisoner admitted to the SMHU pursuant to a direction referred to in section 68(1)(i), whichever of the following events first occurs:

(i) the end of the period specified in the direction or in an agreement made under section 36A(6) of the *Corrections Act 1997*;

(ii) the end of the 48-hour period immediately after the CFP requires the Director to remove the patient from the SMHU under section 36A(7) of the *Corrections Act 1997*;

(iii) the end of the 48-hour period immediately after the CFP decides under section 70 that it would be appropriate for the patient to be returned to the custody of the Director;

(iv) the patient is released from prison on parole under the *Corrections Act 1997*;

(v) if the patient is a detainee within the meaning of the *Corrections Act 1997*, the order remanding or otherwise committing the patient to prison ends;

(vi) the patient completes his or her sentence of imprisonment; or

(e) if the patient is a youth detainee admitted to the SMHU pursuant to a direction referred to in section 68(1)(j), whichever of the following events first occurs:

(i) the end of the period specified in the direction;

(ii) the end of the 48-hour period immediately after the CFP requires the Secretary (Youth Justice) to remove the patient from the SMHU under section 134A(5) of the *Youth Justice Act 1997*;

(iii) the end of the 48-hour period immediately after the CFP decides under section 70 that it would be appropriate for the patient to be returned to the custody of the Secretary (Youth Justice);

(iv) the patient is released from detention on a supervised release order under the *Youth Justice Act 1997*;

(v) if the patient has not been sentenced for the offence in respect of which he or she is being detained in custody, the order remanding or otherwise committing him or her to a detention centre ends;

(vi) the patient completes his or her sentence of imprisonment.

70. Certain forensic patients may request return to prison, &c.

(1) This section applies to a forensic patient, referred to in section 68(1)(i) or (j), who is in an SMHU and whose removal to the SMHU was directed at the patient's own request.

(2) The patient may request to be returned to the custody of the relevant authority at any time.

(3) The request is to be made to the CFP in writing.

(4) The forensic patient may ask any SMHU staff member for help in making the request and the SMHU staff member is to –

(a) render that help to the best of his or her ability; or

(b) arrange for another SMHU staff member to render that help.

(5) The CFP is to have the patient examined by an approved medical practitioner as soon as practicable after receiving the request.

(6) After the examination, the CFP may –

(a) agree to the request; or

(b) refuse the request.

(7) In considering the request, the CFP is to have regard to –

(a) the results of the examination; and

(b) whether or not the reasons for the patient's admission are still valid; and

(c) such other matters as the CFP considers relevant.

(8) If the CFP agrees to the request –

(a) the CFP, without undue delay, is to request the relevant authority to remove the patient from the SMHU; and

(b) the patient is to be removed from the SMHU and transferred to the custody of the relevant authority within 48 hours after the request is agreed to; and

(c) the patient ceases to be taken to be a forensic patient from the time he or she is so removed from the SMHU.

(9) If the CFP refuses the request –

(a) the CFP is to give notice of the refusal, with reasons, to the patient (together with a statement of rights in a CFP approved form); and

(b) the CFP is to give notice of the refusal, with reasons, to the Tribunal.

(10) The CFP is to make and retain an appropriate record of the request and the CFP's decision on the request.

(11) In this section –

relevant authority means –

(a) for a forensic patient referred to in section 68(1)(i), the Director; or

(b) for a forensic patient referred to in section 68(1)(j), the Secretary (Youth Justice).

Note 1 The refusal of a request under this section is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

Note 2 The process by which a forensic patient to whom this section applies may be admitted to or discharged from an SMHU is provided for under the *Corrections Act 1997* and the *Sentencing Act 1997*.

Division 2 – Custody

71. Custody

(1) This section applies to, and in relation to –

(a) a forensic patient who is admitted to an SMHU and has not been discharged or transferred to an approved hospital under section 64(5); and

(b) a forensic patient –

(i) who is admitted to an SMHU and who is subsequently transferred under this Act to a place of transfer (other than under section 64(5)); and

(ii) who has not been discharged from the SMHU or transferred to an approved hospital under section 64(5).

(2) A forensic patient to whom this section applies is taken to be in the custody of the controlling authority of the SMHU throughout the period of his or her detention in the SMHU or place of transfer unless –

(a) a court orders otherwise; or

(b) a provision of this Part expressly provides otherwise.

(3) Subsection (2) continues, despite section 74, to have effect during any period that the patient is away from the SMHU on a leave of absence or for any other purpose authorised by or under this Part.

(4) In this section –

place of transfer means –

(a) a secure institution; or

(b) an approved hospital; or

(c) a health service within the meaning of the *Health Complaints Act 1995* or premises where such a health service is provided; or

(d) any other place to which a patient is transferred under this Act.

Division 3 – Patient movements

72. Transfer of forensic patients between SMHUs

(1) The CFP may direct that a forensic patient be transferred from one SMHU to another if satisfied that the transfer is necessary for –

(a) the patient's health or safety; or

(b) the safety of other persons.

(2) The direction (the *transfer direction*) is to be in a CFP approved form, specifying the mode and conditions of transport, and is invalid if not in that form.

(3) The CFP is to –

(a) give a copy of the transfer direction to the patient (together with a statement of rights in a CFP approved form); and

(b) give a copy of the transfer direction to –

(i) the controlling authority of each SMHU; and

(ii) the treating medical practitioner; and

(iii) the Tribunal; and

(c) place a copy of the transfer direction on the patient's clinical record.

(4) The CFP is to ensure that, if practicable, the actions required by subsection (3)(a) or (b) are taken before the transfer takes place.

(5) The transfer direction is authority for an authorised person or police officer to –

(a) take the patient under escort; and

(b) remove the patient from the SMHU where he or she is being detained; and

(c) take the patient to the other SMHU.

(6) For the purposes of subsection (5) –

(a) the CFP may request that the patient be taken under escort (in which case the CFP is to ensure that the escort is given a copy of the transfer direction); and

(b) the custody and escort provisions apply; and

(c) while the patient is being transferred, the escort has, as regards the patient, for all purposes connected with the transfer, full authority to act in the name of the controlling authority of the SMHU from which the patient is being transferred and to discharge any of the responsibilities of authorised persons under this Part.

(7) Once the patient has been transferred, an order for the patient's detention has effect as if it provided for the patient's detention in the other SMHU.

Note The transfer of a forensic patient under this section is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

73. Transfer of forensic patients to hospitals, &c.

(1) The CFP may direct that a forensic patient be removed from an SMHU and transferred to a secure institution, an approved hospital, a health service, within the meaning of the *Health Complaints Act 1995*, or premises where such a health service is provided.

(2) Except in an emergency, the direction (the *transfer direction*) is to be in a CFP approved form.

(3) In an emergency, the transfer direction may be given orally or by any other convenient means and, in such a case, the CFP may complete the transfer direction after the transfer takes place.

(4) The transfer direction (or, if applicable, emergency oral direction) is authority for an authorised person or police officer to –

(a) take the patient under escort; and

(b) remove the patient from the SMHU; and

(c) take the patient to the secure institution, approved hospital, health service or premises specified in the direction.

(5) For the purposes of subsection (4) –

(a) the CFP may request that the patient be taken under escort (in which case the CFP is to ensure that the escort is given a copy of the transfer direction); and

(b) the custody and escort provisions apply; and

(c) while the patient is being transferred and is in the secure institution, approved hospital, health service or premises pursuant to the transfer direction, the escort has, as regards the patient, for all purposes connected with the transfer, full

authority to act in the name of the controlling authority of the SMHU and to discharge any responsibility of any authorised person under this Part.

(6) The CFP is to –

(a) give a copy of the transfer direction to the patient (together with a statement of rights in a CFP approved form); and

(b) give a copy of the transfer direction to –

(i) the controlling authority of the SMHU; and

(ii) the person in charge of the secure institution, approved hospital, health service or other place to which the patient is transferred; and

(iii) the treating medical practitioner; and

(iv) the Tribunal; and

(c) place a copy of the transfer direction on the patient's clinical record.

Note The transfer of a forensic patient under this section is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

74. Application of Part to places other than SMHUs

(1) This section applies if a forensic patient in the custody of the controlling authority of an SMHU

is being detained in a secure institution, an approved hospital, a health service within the meaning of the *Health Complaints Act 1995* or premises where such a health service is provided or another place.

(2) The provisions of this Part apply –

(a) in respect of the forensic patient as if he or she were in the SMHU; and

(b) in respect of the secure institution, approved hospital, health service, premises or other place as if it were the SMHU.

Division 4 – Return of forensic patients to SMHUs

75. Return of forensic patient in Tasmania to SMHU

(1) This section applies if, while in the custody of the controlling authority of an SMHU, a forensic patient who is not subject to a restriction order –

(a) absconds from that custody; or

(b) fails, while on a leave of absence from the SMHU, to comply with the terms or conditions of that leave; or

(c) is on a leave of absence from the SMHU and the leave expires.

(2) The controlling authority, by instrument in writing, may authorise an authorised person or

police officer to take the patient into protective custody and return the patient to the SMHU.

(3) For the purposes of subsection (2) the custody and escort provisions apply.

(4) However, the power under subsection (2) is not to be exercised if, at the relevant time, the patient would no longer be liable to be admitted to the SMHU as a forensic patient.

(5) In this section –

leave of absence means leave of absence granted under Division 5 or 6.

Note The return to an SMHU of a forensic patient subject to a restriction order is provided for in the *Criminal Justice (Mental Impairment) Act 1999*.

76. Return of forensic patient outside Tasmania to SMHU

(1) This section applies to a forensic patient who is not –

(a) subject to an order of detention referred to in section 41(1A) of the *Criminal Justice (Mental Impairment) Act 1999*; or

(b) subject to a continuing care order referred to in section 41(1B) of the *Criminal Justice (Mental Impairment) Act 1999*.

(2) If a magistrate is satisfied that –

(a) the patient should be in the custody of the controlling authority of an SMHU; and

(b) there are reasonable grounds to suspect that the patient has absconded from that custody and is no longer in Tasmania –

the magistrate may issue a warrant authorising the patient's arrest and his or her return to the SMHU.

(3) A warrant under subsection (2) is not to be held void by reason of a formal defect in it.

Division 5 – Leave of absence for forensic patients subject to restriction orders

77. Definitions for this Division

In this Division –

interested person means –

(a) the CFP; and

(b) the controlling authority of the SMHU; and

(c) the person who applied for the leave (if not the patient); and

(d) if applicable, the patient's intended escort; and

(e) the Director (Corrective Services); and

(f) the Commissioner of Police; and

(g) the Secretary(Corrections);

responsible authority means –

(a) the Tribunal; or

(b) the CFP; or

(c) the controlling authority of the SMHU; or

(d) the Secretary; or

(e) the treating medical practitioner; or

(f) an approved medical practitioner.

78. When leave of absence for forensic patients subject to restriction orders may be granted

(1) The Tribunal may grant a forensic patient who is subject to a restriction order leave of absence in Tasmania (*leave*), unless the restriction order expressly provides to the contrary.

(2) The leave may be granted for clinical or personal reasons.

(3) Leave for clinical reasons may be granted only on the application of the CFP.

(4) Leave for personal reasons may be granted only on the application of –

(a) the patient; or

(b) the CFP; or

(c) by leave of the Tribunal, a person who, in the opinion of the CFP, has a genuine interest in the person's welfare.

(5) The patient may ask any SMHU staff member for help in making the request and the SMHU staff member is to –

(a) render that help to the best of his or her ability; or

(b) arrange for another SMHU staff member to render that help.

(6) The application is to be in accordance with section 195.

(7) Once the application has been made, the following provisions apply:

(a) the Tribunal is to notify the Secretary (Corrections) of the application;

(b) the Secretary (Corrections) is to check the Eligible Persons Register to determine whether there are any eligible persons in relation to the patient;

(c) if there are such eligible persons, the Secretary (Corrections) is to make a reasonable attempt to notify each of them of the application and of their right to make written submissions in respect of it

within 10 days after the eligible person is notified;

(d) the Tribunal is to notify any other person who, in the Tribunal's opinion, should be notified of the application and of that person's right to make written submission in respect of it within 10 days after being notified of the application.

(8) The Tribunal is to consider any submissions received pursuant to subsection (7) before granting or refusing to grant the leave.

(9) The leave –

(a) may be granted in person (by any member of the Tribunal), in writing or by any other available means of communications; and

(b) may be granted for a particular purpose or for a particular period, or both; and

(c) is to be granted on such conditions as the Tribunal considers necessary or desirable for the patient's health or safety or the safety of other persons.

(10) Without limiting the generality of subsection (9)(c), the patient may be required to be under escort during the leave or any portion thereof (in which case the custody and escort provisions apply).

(11) If the leave is granted for a particular purpose without a particular period being specified, the CFP may determine the period of leave.

(12) If subsection (11) applies, the CFP is to –

(a) make an appropriate record of the matter; and

(b) give a copy of the record to the Tribunal, the patient and each interested person; and

(c) place a copy of the record on the patient's clinical record.

(13) Whether the leave is granted or refused, the Tribunal is to –

(a) make an appropriate record of the matter (including, if applicable, the terms and conditions of the leave); and

(b) give to the patient a copy of the record together with a statement of rights in an MHT approved form; and

(c) give a copy of the record to each interested person.

(14) Nothing in this section applies to the attendance of the patient in court.

79. Extension, variation and cancellation of leave of absence

(1) If leave of absence (*leave*) is granted under section 78, the Tribunal, by notice to the patient, may at any time –

(a) extend the leave; or

(b) vary the conditions of the leave.

(2) An extension of leave or variation of the conditions of leave may be granted under subsection (1) only –

(a) if the leave is for clinical reasons, on the application of the CFP; or

(b) if the leave is for personal reasons, on the application of –

(i) the patient; or

(ii) the CFP; or

(iii) by leave of the Tribunal, a person who, in the opinion of the CFP, has a genuine interest in the patient's welfare.

(3) An application for extension of leave must be lodged at least 10 days before the leave expires.

(4) To avoid doubt –

(a) a power under subsection (1) may be exercised more than once; and

(b) a variation pursuant to subsection (1)(b) may be expressed to have immediate or deferred effect.

(5) On issuing a notice under subsection (1), the Tribunal is to give a copy of the notice to each interested person.

(6) An application for extension of leave or variation of the conditions of leave may be determined without a hearing.

(7) A responsible authority, by notice to the patient, may cancel the leave at any time if the responsible authority believes that its continuation would, or is likely to –

(a) seriously endanger the patient's health or safety; or

(b) place the safety of other persons at serious risk.

(8) On issuing a notice under subsection (7), the responsible authority is to –

(a) make an appropriate record of the cancellation; and

(b) give a copy of the record to each interested person; and

(c) give a copy of the record to the Tribunal (if the Tribunal is not the responsible authority); and

(d) place a copy of the record on the patient's clinical file.

(9) On the cancellation, an MHO or police officer may apprehend and return the patient under escort to the SMHU (for which purpose the custody and escort provisions apply).

(10) Where, under this section, a patient is required to give a document to the patient (or to a person who has applied for leave of absence for and on behalf of the patient), the person is to ensure that the document is accompanied by a statement of rights in a CFP approved form.

(11) Nothing in this section applies to the attendance of the patient in court.

80. Victims to be notified of leave of absence of patient

(1) If a forensic patient has been granted under section 78 a leave of absence from an SMHU, the controlling authority of the SMHU must not allow the patient to actually take the leave of absence without first notifying the Secretary (Corrections) and ensuring that –

(a) the Secretary (Corrections) has notified each eligible person in relation to the patient of the grant of the leave and the terms and conditions of the leave; or

(b) circumstances have rendered it impossible, impracticable or inappropriate for the Secretary (Corrections) to give such notice in a particular case.

(2) Subsection (1) prevails over –

(a) section 78; and

(b) any order or direction of the Tribunal or the CFP; and

(c) any standing orders.

(3) If the Secretary (Corrections) is notified of an extension under section 79 of a forensic patient's leave of absence, any variation of the conditions of the patient's leave of absence or the cancellation of the patient's leave of absence, the Secretary (Corrections) is to make a reasonable attempt to give each eligible person in relation to the patient notice of the extension, variation or cancellation.

Division 6 – Leave of absence for forensic patients not subject to restriction orders

81. Definitions for this Division

In this Division –

interested person means –

(a) the controlling authority of the SMHU; and

(b) the person who applied for the leave (if not the patient); and

(c) if applicable, the patient's intended escort; and

(d) the Tribunal; and

(e) the Commissioner of Police; and

(f) if applicable, the Secretary (Corrections); and

(g) if applicable, the Director; and

(h) if applicable, the Secretary (Youth Justice);

responsible authority means –

(a) the CFP; or

(b) the controlling authority of the SMHU; or

(c) the treating medical practitioner; or

(d) an approved medical practitioner.

82. When leave of absence for forensic patients not subject to restriction orders may be granted

(1) The CFP may grant a forensic patient who is not subject to a restriction order leave of absence in Tasmania (*leave*).

Note The application of this provision to an involuntary patient who is taken to be a forensic patient is modified by section 67.

(2) The leave may be granted for clinical or personal reasons.

(3) Leave for clinical reasons may be granted only on the application of the treating medical practitioner.

(4) Leave for personal reasons may be granted only on the application of –

(a) the patient; or

(b) a person who, in the opinion of the CFP, has a genuine interest in the person's welfare.

(5) The forensic patient may ask any SMHU staff member for help in making the request and the SMHU staff member is to –

(a) render that help to the best of his or her ability; or

(b) arrange for another SMHU staff member to render that help.

(6) The application may be made by any person, in writing or by any other available means of communication.

(7) Once the application has been made, the following provisions apply:

(a) the CFP is to notify the Secretary (Corrections) of the application;

(b) the Secretary (Corrections) is to check the Eligible Persons Register to determine whether there are any eligible persons in relation to the patient;

(c) if there are such eligible persons, the Secretary (Corrections) is to make a reasonable attempt to notify each of them of the application and of their right to make written submissions in respect of it within 10 days after the eligible person is notified;

(d) if the patient is a prisoner or detainee under the *Corrections Act 1997*, the CFP is to notify the Director of the application and of the Director's right to make written submissions in respect of it within 10 days after being notified of the application;

(e) if the patient is a youth detainee, the CFP is to –

(i) notify the Secretary (Youth Justice) of the application and of that Secretary's right to make written submissions in respect of it within 10 days after being notified of the application; and

(ii) ask, specifically, whether the Secretary (Youth Justice) consents to it;

(f) the CFP is to notify any other person who, in the CFP's opinion, should be notified of the application and of that person's right to make written submissions in respect of it within 10

days after being notified of the application.

(8) The CFP is to consider any submissions received pursuant to subsection (7) before granting or refusing to grant the leave.

(9) Also, if the patient is a youth detainee, the leave may be granted only with the consent of the Secretary (Youth Justice).

(10) The leave –

(a) may be granted in person, in writing or by any other available means of communications; and

(b) may be granted for a particular purpose or for a particular period, or both; and

(c) is to be granted on such conditions as the CFP considers necessary or desirable for the patient's health or safety or the safety of other persons.

(11) Without limiting the generality of subsection (10)(c), the patient may be required to be under escort during the leave or any portion thereof (in which case the custody and escort provisions apply).

(12) If the leave is granted for a particular purpose without a particular period being specified, the treating medical practitioner may determine the period of leave.

(13) If subsection (12) applies, the treating medical practitioner is to –

(a) make an appropriate record of the matter; and

(b) give a copy of the record to the patient and each interested person; and

(c) place a copy of the record on the patient's clinical record.

(14) Whether the leave is granted or refused, the CFP is to –

(a) make an appropriate record of the matter (including, if applicable, the terms and conditions of the leave); and

(b) give a copy of the record to the patient and each interested person.

(15) Nothing in this section applies to the attendance of the patient in court.

83. Extension, variation and cancellation of leave of absence

(1) If leave of absence (*leave*) is granted under section 82, the CFP, by notice to the patient, may at any time –

(a) extend the leave; or

(b) vary the conditions of the leave.

(2) If the patient is a youth detainee, the extension or variation requires the consent of the Secretary (Youth Justice).

(3) To avoid doubt –

(a) a power under subsection (1) may be exercised more than once; and

(b) a variation pursuant to subsection (1)(b) may be expressed to have immediate or deferred effect.

(4) On issuing a notice under subsection (1), the CFP is to –

(a) give a copy of the notice to each interested person; and

(b) place a copy of the notice on the patient's clinical record.

(5) A responsible authority, by notice to the patient, may cancel the leave at any time if the responsible authority believes that its continuation would, or is likely to –

(a) seriously endanger the patient's health or safety; or

(b) place the safety of other persons at serious risk.

(6) On issuing a notice under subsection (5), the responsible authority is to –

(a) make an appropriate record of the cancellation; and

(b) give a copy of the record to each interested person; and

(c) give a copy of the record to the CFP (if the CFP is not the responsible authority); and

(d) place a copy of the record on the patient's clinical file.

(7) On the cancellation, an MHO or police officer may apprehend and return the patient under escort to the SMHU (for which purpose the custody and escort provisions apply).

(8) Where, under this section, a person is required to give a document to the patient (or to a person who has applied for leave of absence for and on behalf of the patient), the person is to ensure that the document is accompanied by a statement of rights in a CFP approved form.

(9) Nothing in this section applies to the attendance of the patient in court.

84. Victims to be notified of leave of absence of patient

(1) If a forensic patient (other than a person who is taken to be a forensic patient under section 66) has been granted under section 82 leave of absence from an SMHU, the controlling authority of the SMHU must not allow the patient to actually take the leave of absence without first checking with the Secretary (Corrections) that –

(a) the Secretary (Corrections) has notified each eligible person in relation to the patient of the grant of the leave and the terms and conditions of the leave; or

(b) circumstances have rendered it impossible, impracticable or inappropriate for the Secretary (Corrections) to give such notice in a particular case.

(2) Subsection (1) prevails over –

(a) section 82; and

(b) any order or direction of the Tribunal or the CFP; and

(c) any standing orders.

(3) If the Secretary (Corrections) is notified of an extension under section 83 of a forensic patient's leave of absence, any variation of the conditions of the patient's leave of absence or the cancellation of the patient's leave of absence, the Secretary (Corrections) is to make a reasonable attempt to give each eligible person in relation to the patient notice of the extension, variation or cancellation.

PART 5 – TREATMENT AND MANAGEMENT OF FORENSIC PATIENTS

Division 1 – Interpretation and application

85. Interpretation of Part

In this Part –

privileged, visitor, caller or correspondent – see section 98;

proper grounds, for the refusal or termination of any visiting, telephone or correspondence rights of or in respect of a forensic patient, means that the exercise of the right –

(a) is or might be for an unlawful purpose; or

(b) is or might be detrimental to the management, good order or security of the SMHU; or

(c) is or might be harmful, distressing or offensive to the patient or another person; or

(d) is or might be detrimental to the health or safety of the patient; or

(e) is or might be interfering with the patient's treatment; or

(f) is or might be inopportune because the patient is seriously or acutely unwell; or

(g) should, having regard to any proper matter, not be allowed on account of some other compelling reason or risk;

responsible official, for an SMHU, means its controlling authority, the CFP or an authorised person at the SMHU;

visitor, to an SMHU, includes –

(a) a person who is seeking to enter the SMHU as a visitor; and

(b) a person who is completing a visit.

86. Application of Part to places other than SMHUs

(1) This section applies if a forensic patient in the custody of the controlling authority of an SMHU is being detained in a secure institution, an approved hospital, a health service within the meaning of the *Health Complaints Act 1995* or premises where such a health service is provided or another place.

(2) The provisions of this Part, as modified under subsection (3), apply –

(a) in respect of the forensic patient as if he or she were in the SMHU; and

(b) in respect of the secure institution, approved hospital, health service, premises or other place as if it were the SMHU.

(3) In its application under this section to a health service within the meaning of the *Health Complaints Act 1995*, or premises where such a health service is provided or another place, section 113(1) is modified by omitting "bring into an SMHU" and substituting "bring into the part of the SMHU in which a patient is being detained".

Division 2 – Treatment of forensic patients

87. Urgent circumstances treatment

(1) A forensic patient may be given treatment (*urgent circumstances treatment*) without informed consent or Tribunal authorisation if the CFP authorises the treatment as being urgently needed in the patient's best interests.

(2) The CFP may, under subsection (1), authorise treatment as being urgently needed in the patient's best interests only if the CFP is of the opinion that achieving the necessary treatment outcome would be compromised by waiting for the urgent circumstances treatment to be authorised by the Tribunal (or by a member thereof on an interim basis).

(3) The authorisation may be given on the application of any medical practitioner involved in the patient's treatment or care (the *applicant*).

(4) The application may be made by any means acceptable to the CFP in the circumstances.

(5) The CFP may give the authorisation if, and only if –

(a) an approved medical practitioner has concluded from an assessment that –

(i) the patient has a mental illness that is generally in need of treatment; and

(ii) the urgent circumstances treatment is necessary for –

(A) the patient's health or safety; or

(B) the safety of other persons; and

(iii) the urgent circumstances treatment is likely to be both effective and appropriate in terms of the outcomes referred to in section 6(1); and

(iv) achieving the necessary treatment outcome would be compromised by waiting for the urgent circumstances treatment to be authorised by the Tribunal (or by

a member thereof on an interim basis); and

(b) the CFP agrees with the approved medical practitioner's conclusion; and

(c) the CFP is satisfied that a reasonable attempt to give the patient the urgent circumstances treatment with informed consent has failed or that it would be futile or inappropriate to make such an attempt.

(6) If the authorisation is given, the CFP is to advise the following persons or bodies of the authorisation without delay:

(a) the applicant;

(b) the approved medical practitioner (if it is someone other than the applicant);

(c) the Tribunal.

(7) The advice under subsection (6) may be given by any means of communication the CFP considers appropriate in the circumstances but, if it is given orally, the CFP is to confirm it in writing by means of a CFP approved form.

(8) If the authorisation is given, the applicant has the following obligations:

(a) to give a copy of the authorisation to the patient (together with a statement of rights in a CFP approved form);

(b) to place a copy of the authorisation on the patient's clinical record.

(9) If the authorisation is given, the patient may be given the urgent circumstances treatment until whichever of the following first occurs:

(a) the treatment is completed;

(b) the CFP, for any reason he or she considers sufficient, revokes the authorisation;

(c) an approved medical practitioner, for any reason he or she considers sufficient, stops the urgent circumstances treatment;

(d) the 96-hour period immediately following the giving of the authorisation expires;

(e) the authorisation is set aside by the Tribunal.

(10) To avoid doubt and, without limiting the generality of section 149, in this section –

CFP includes a delegate of the CFP.

Note The authorisation of urgent circumstances treatment is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

88. Authorisation of treatment by Tribunal

(1) The Tribunal may authorise treatment for a forensic patient if satisfied that –

(a) the treatment has been recommended and applied for by an approved medical practitioner (the *applicant*) in accordance with section 195; and

(b) the patient has a mental illness; and

(c) without the treatment, the mental illness will, or is likely to, seriously harm –

(i) the patient's health or safety; or

(ii) the safety of other persons; and

(d) the treatment will be appropriate and effective in terms of the outcomes referred to in section 6(1); and

(e) the patient does not have decision-making capacity.

(2) The Tribunal is to determine the application by way of a hearing before a division of the Tribunal constituted by 3 members.

(3) The treatment may be authorised unconditionally or on such conditions as to time, method, supervision or otherwise as the Tribunal considers necessary or desirable and specifies in the authorisation.

(4) The authorisation is to be in an MHT approved form.

(5) The Tribunal is to –

(a) give a copy of the authorisation to the patient (together with a statement of rights in an MHT approved form); and

(b) give a copy of the authorisation to –

(i) the applicant; and

(ii) the CFP.

(6) The authorisation has effect according to its terms.

89. Discharge of Tribunal treatment authorisation

The Tribunal may discharge an authorisation under section 88 at any time while the patient is a forensic patient.

90. Authorisation becomes treatment order when person ceases to be forensic patient

If a patient to whom an authorisation under section 88 applies ceases to be a forensic patient on a day, the authorisation is taken to be a treatment order in relation to the person on and from that day for a period of 6 months, unless the treatment order is discharged or otherwise ceases to be in effect.

91. Interim authorisation of treatment by Tribunal member

(1) A single member of the Tribunal (the *MHT member*) may authorise treatment for a forensic patient if satisfied that –

(a) the treatment has been recommended and applied for by an approved medical practitioner (the *applicant*) in accordance with section 195; and

(b) the Tribunal cannot immediately determine the application; and

(c) the criteria specified in section 88(1)(b), (c), (d) and (e) are satisfied; and

(d) achieving the treatment outcomes would be compromised by waiting for the treatment to be authorised by the Tribunal.

(2) The MHT member may authorise the treatment on the basis of the application alone, without any hearing or further investigation.

(3) The treatment may be authorised unconditionally or on such conditions as to time, method, supervision or otherwise as the MHT member considers necessary or desirable and specifies in the authorisation.

(4) The MHT member is to advise the patient, the applicant and the CFP of the authorisation without delay, and this may be done by any

means of communication the MHT member considers appropriate in the circumstances.

(5) However, if the advice of the authorisation is given orally, the MHT member is to confirm it in writing by means of an MHT approved form.

(6) The MHT member or the Tribunal may revoke or vary the authorisation at any time.

(7) The MHT member or the Tribunal, as the case may be, is to advise the patient, applicant and CFP of the revocation or variation of the authorisation without delay, and this may be done by any means of communication the MHT member or Tribunal considers appropriate in the circumstances.

(8) However, if the advice of the revocation or variation of the authorisation is given orally, the MHT member or the Tribunal, as the case may be, is to confirm it in writing by means of an MHT approved form.

(9) Subject to subsection (6), the authorisation continues in effect according to its terms until the relevant application is determined by the Tribunal.

(10) However, the authorisation lapses after 14 days (calculated from the precise time it is given) if, by then, the Tribunal has not determined the relevant application.

(11) Once an advice under subsection (4) or (7) has been put in writing, the MHT member or the Tribunal, as the case may be, is to –

(a) give a copy of the advice to the patient (together with a statement of rights in an MHT approved form);

(b) give a copy of the advice to –

(i) the applicant; and

(ii) the CFP.

Division 3 – Force, seclusion and restraint

92. Interpretation of Division

In this Division –

prescribed reason, for applying force to a forensic patient or placing a forensic patient in seclusion or under restraint, means –

(a) to facilitate the patient's treatment; or

(b) to facilitate the patient's general health care; or

(c) to ensure the patient's health or safety; or

(d) to ensure the safety of other persons; or

(e) to prevent the patient from destroying or damaging property; or

(f) to prevent the patient's escape from lawful custody; or

(g) to provide for the management, good order or security of the SMHU; or

(h) to facilitate the patient's lawful transfer to or from another facility, whether in this State or elsewhere; or

(i) a reason sanctioned by CFP standing orders.

93. Force

(1) Except if authorised under any other law, force may be applied to a forensic patient if, and only if –

(a) by reason of the physical violence, resistance or disturbance of the patient, the force is necessary –

(i) for a prescribed reason; or

(ii) to place the patient in seclusion or under restraint; and

(b) the force is applied solely by appropriate persons or their assistants; and

(c) the force is no more excessive, unusual or prolonged than is reasonably justified in the circumstances.

(2) Nothing in this section is to be taken as conferring any kind of authority for force to be applied to a forensic patient as a means of punishment or for reasons of administrative or staff convenience.

(3) In this section –

appropriate person means –

(a) a member of the SMHU staff; or

(b) a medical practitioner; or

(c) a nurse; or

(d) an authorised person; or

(e) a person who has or is entitled to take immediate lawful custody of the patient.

Note 1 The application of force to a forensic patient is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

Note 2 The CFP has power to intervene in such circumstances – see section 147.

94. Seclusion

(1) Except if authorised under any other law, a forensic patient may be placed in seclusion if, and only if –

(a) the seclusion is authorised as being necessary for a prescribed reason, by –

(i) for a patient who is a child, the CFP; or

(ii) for any other patient, the CFP, a medical practitioner or approved nurse; and

(b) the person authorising the seclusion is satisfied that it is a reasonable intervention in the circumstances; and

(c) the seclusion lasts for no longer than authorised under this section; and

(d) the seclusion is managed in accordance with any relevant CFP standing orders or clinical guidelines.

(2) If a forensic patient is placed in seclusion under this section –

(a) the patient must be clinically observed by a member of the SMHU nursing staff at intervals not exceeding 15 minutes or at such different intervals as CFP standing orders may mandate; and

(b) the patient must be examined by a medical practitioner or approved nurse at intervals not exceeding 4 hours to see if the seclusion should continue or be terminated; and

(c) the patient must also be examined by an approved medical practitioner at intervals not exceeding 12 hours; and

(d) the seclusion must not extend beyond 7 hours unless –

(i) the patient has been examined by a medical practitioner within those 7 hours; and

(ii) the extension is authorised by the CFP within those 7 hours; and

(iii) if applicable, each subsequent extension (regardless of duration) is also authorised in advance by the CFP; and

(e) the CFP may impose conditions on any extension authorised under paragraph (d); and

(f) the CFP, on authorising an initial extension of the seclusion, must stipulate the maximum timeframe for its continuance; and

(g) the patient must be provided with –

(i) suitable clean clothing and bedding; and

(ii) adequate sustenance; and

(iii) adequate toilet and sanitary arrangements; and

(iv) adequate ventilation and light; and

(v) a means of summoning aid; and

(h) the administration of any prescribed medications to the patient must not be unreasonably denied or delayed; and

(i) the patient must not be deprived of physical aids except as may be strictly necessary for the patient's safety or the preservation of those physical aids for the patient's future use; and

(j) regardless of authorisation, the seclusion must not be maintained to the obvious detriment of the patient's mental or physical health.

(3) To avoid doubt, a forensic patient's seclusion is not taken to have been interrupted or terminated merely by reason of –

(a) a scheduled observation or examination under subsection (2); or

(b) the giving of any necessary treatment or general health care.

(4) Nothing in this section is to be taken as conferring any kind of authority for a forensic patient to be placed in seclusion as a means of punishment or for reasons of administrative or staff convenience.

Note 1 The seclusion of a forensic patient is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

Note 2 The CFP has power to intervene in such circumstances – see section 147.

95. Restraint

(1) Except if authorised under any other law, a forensic patient may be placed under restraint if, and only if –

(a) the restraint is authorised as being necessary for a prescribed reason by –

(i) in the case of chemical or mechanical restraint, the CFP; or

(ii) in the case of physical restraint where the patient is a child, the CFP; or

(iii) in the case of physical restraint where the patient is not a child, the CFP, a medical practitioner or an approved nurse; and

(b) the person authorising the restraint is satisfied that it is a reasonable intervention in the circumstances; and

(c) the restraint lasts for no longer than authorised under this section; and

(d) the means of restraint employed in the specific case is, in the case of mechanical restraint, approved in advance by the CFP; and

(e) the restraint is managed in accordance with any relevant CFP standing orders or clinical guidelines.

(2) If a forensic patient is placed under restraint under this section –

(a) the patient must be clinically observed by a member of the SMHU nursing staff at intervals not exceeding 15 minutes or at such different intervals as CFP standing orders may mandate; and

(b) the patient must be examined by a medical practitioner or approved nurse at intervals not exceeding 4 hours to see if the restraint should continue or be terminated; and

(c) the patient must also be examined by an approved medical practitioner at intervals not exceeding 12 hours; and

(d) the restraint must not extend beyond 7 hours unless –

(i) the patient has been examined by a medical practitioner within those 7 hours; and

(ii) the extension is authorised by the CFP within those 7 hours; and

(iii) if applicable, each subsequent extension (regardless of duration) is also authorised in advance by the CFP; and

(e) the CFP may impose conditions on any extension authorised under paragraph (d); and

(f) the CFP, on authorising an initial extension of the restraint, must stipulate the maximum timeframe for its continuance; and

(g) the patient must be provided with –

(i) suitable clean clothing and bedding; and

(ii) adequate sustenance; and

(iii) adequate toilet and sanitary arrangements; and

(iv) adequate ventilation and light; and

(v) a means of summoning aid; and

(h) the administration of any prescribed medications to the patient must not be unreasonably denied or delayed; and

(i) the patient must not be deprived of physical aids except as may be strictly necessary for the patient's safety or the preservation of those physical aids for the patient's use; and

(j) regardless of authorisation, the restraint must not be maintained to the obvious detriment of the patient's mental or physical health.

(3) Nothing in this section is to be taken as conferring any kind of authority for a forensic patient to be placed under restraint as a means of

punishment or for reasons of administrative or staff convenience.

(4) However, nothing in this section applies to or prevents the emergency short-term physical restraint of a patient, subject to and in accordance with relevant CFP standing orders or clinical guidelines, so as to –

(a) prevent the patient from harming himself or herself or others; or

(b) prevent the patient from damaging, or interfering with the operation of, a facility or any equipment; or

(c) break up a dispute or affray involving the patient; or

(d) ensure, if he or she is uncooperative, the patient's movement to or attendance at any place for a lawful purpose.

(5) Notwithstanding the discretionary nature of the power under section 152(1), the CFP must ensure that CFP standing orders are issued for this section.

Note 1 The restraint of a forensic patient is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

Note 2 The CFP has power to intervene in such circumstances – see section 147.

96. Records, &c.

(1) This section applies if –

(a) force is applied to a forensic patient otherwise than under any other law; or

(b) a forensic patient is placed in seclusion or under restraint otherwise than under any other law.

(2) The controlling authority is to –

(a) make an appropriate record of the matter; and

(b) give a copy of the record to the CFP and the Tribunal; and

(c) place a copy of the record on the patient's clinical record.

(3) The CFP or Tribunal, by notice, may require the controlling authority to provide further information about the matter within a required time and the controlling authority is to comply with that requirement.

Division 4 – Visits

97. Patient visiting rights

(1) A forensic patient has –

(a) the right to receive visitors; and

(b) the right to refuse to receive visitors.

(2) However, the rights conferred by subsection (1) may be exercised only in accordance with this Act.

Note 1 The exercise of visiting rights under this Division is, for non-police visits, reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

Note 2 The CFP has power to intervene in respect of the exercise of such rights in circumstances where the CFP is not the relevant decision-maker – see section 147.

98. Privileged visitors, callers and correspondents

(1) For the purposes of this Act, a person is a privileged visitor if he or she is one of the following:

(a) the Principal Official Visitor or an Official Visitor;

(b) a judge, associate judge or magistrate;

(c) the Ombudsman, the Deputy Ombudsman or a member of the Ombudsman's staff;

(d) a Chief Psychiatrist;

(e) a member of the Tribunal, the Registrar of the Tribunal or an MHT staff member;

(f) the Health Complaints Commissioner or a member of that Commissioner's staff;

(g) the Anti-Discrimination Commissioner or a member of that Commissioner's staff;

(h) a person prescribed by the regulations.

(2) For the purposes of this Act, a person is a privileged caller if he or she is one of the following:

(a) the Principal Official Visitor or an Official Visitor;

(b) a judge, associate judge or magistrate;

(c) the Ombudsman, the Deputy Ombudsman or a member of the Ombudsman's staff;

(d) a Chief Psychiatrist;

(e) a member of the Tribunal, the Registrar of the Tribunal or an MHT staff member;

(f) the Health Complaints Commissioner or a member of that Commissioner's staff;

(g) the Anti-Discrimination Commissioner or a member of that Commissioner's staff;

(h) an Australian legal practitioner (acting in a professional capacity);

(i) a medical practitioner (acting in a professional capacity);

(j) the Public Guardian, the Deputy Public Guardian or a member of the Public Guardian's staff;

(k) a person prescribed by the regulations.

(3) For the purposes of this Act, a person is a privileged correspondent if he or she is one of the following:

(a) the Principal Official Visitor or an Official Visitor;

(b) a judge, associate judge or magistrate;

(c) the Ombudsman, the Deputy Ombudsman or a member of the Ombudsman's staff;

(d) a Chief Psychiatrist;

(e) a member of the Tribunal, the Registrar of the Tribunal or an MHT staff member;

(f) the Health Complaints Commissioner or a member of that Commissioner's staff;

(g) the Anti-Discrimination Commissioner or a member of that Commissioner's staff;

(h) any court or commission, committee, tribunal or other board connected to the legal process, or an officer of any court or any such commission, committee, tribunal or other board;

(i) the Secretary;

(j) the Secretary (Corrections);

(k) the Secretary (Youth Justice);

(l) a State Authority, within the meaning of the *State Service Act 2000*, that is connected to the legal process or concerned with the rights or treatment of prisoners or patients in hospitals or an officer of such State Authority;

(m) an Australian legal practitioner (acting in a professional capacity);

(n) a medical practitioner (acting in a professional capacity);

(o) the Public Guardian, the Deputy Public Guardian or a member of the Public Guardian's staff;

(p) a person prescribed by the regulations.

(4) The CFP, by notice, may cancel or suspend for a time any individual's privileged visitor, privileged caller or privileged correspondent status if the CFP is satisfied on reasonable grounds that the individual has engaged in behaviour that is incompatible with the management, good order or security of an SMHU.

(5) The cancellation or suspension of the individual's privileged visitor, privileged caller or privileged correspondent status takes effect as soon as he or she is given notice of it.

Note A cancellation or suspension of privileged visitor, privileged caller or privileged correspondent status under this section is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

99. Entry of visitors

(1) A person may enter an SMHU as a visitor at reasonable times and intervals determined by a responsible official.

(2) The responsible official may give the visitor such directions as the responsible official considers necessary or desirable for the management, good order or security of the SMHU.

(3) The visitor must comply with the responsible official's directions.

Penalty: Fine not exceeding 25 penalty units.

(4) This section applies to any visitor, including a privileged visitor.

100. Visitor identity

(1) A responsible official may require a person seeking to enter an SMHU as a visitor to provide proof of identity or status.

(2) The required proof of identity may extend to fingerprints or other biometric data approved by CFP standing orders.

(3) This section applies to any visitor, including a privileged visitor.

101. Visitor information

(1) A responsible official may require a person seeking to enter an SMHU as a visitor to –

(a) explain the nature of the person's relationship to any forensic patient in the SMHU; and

(b) explain the purpose of the visit; and

(c) provide any other relevant information the responsible official may require.

(2) This section applies to any visitor other than a privileged visitor.

102. Refusal of visits

(1) A responsible official –

(a) must refuse to allow a person to enter an SMHU as a visitor if –

(i) the person has not complied fully or at all with a requirement under section 100 or 101; or

(ii) the responsible official is not satisfied as to any information provided under those sections, whether as to its truth or otherwise; and

(b) may refuse to allow a person to enter an SMHU as a visitor if the responsible

official reasonably considers that there are proper grounds to do so.

(2) If the duty or power of refusal under subsection (1) is exercised, the responsible official may direct the person to leave the SMHU forthwith or by a specified time.

(3) The person must comply with the responsible official's direction.

Penalty: Fine not exceeding 25 penalty units.

(4) This section applies to any visitor, including a privileged visitor.

103. Termination of visits

(1) A responsible official may direct a person who has entered an SMHU as a visitor to leave the SMHU forthwith or by a specified time if the responsible official reasonably considers that there are proper grounds to do so.

(2) The responsible official is not obliged to give the visitor reasons for the direction.

(3) The visitor must comply with the direction.

Penalty: Fine not exceeding 25 penalty units.

(4) This section applies to any visitor, including a privileged visitor.

104. Arrest, &c., of visitors who fail to comply with directions

If a visitor to an SMHU fails to comply with a direction under section 99(2), section 102(2) or section 103(1) –

(a) an authorised person, with such assistants and using such force as he or she considers appropriate in the circumstances, may remove the visitor from the SMHU or detain the visitor for such time as is necessary for the visitor to be arrested by a police officer; and

(b) a police officer may arrest the person without warrant.

105. Police visits

(1) A responsible authority may allow a police officer to visit a forensic patient in an SMHU if satisfied that –

(a) it is for the purposes of a police investigation; and

(b) the patient, or any representative of the patient, after being informed of the patient's rights under this section, has no objection.

(2) The visit is to be on such conditions as to time, duration, termination, supervision, setting, secrecy or otherwise as the responsible authority

determines and it is the duty of the police officer to comply with those conditions.

(3) The responsible authority, by any available means, may vary the conditions at any time.

(4) The patient has the following rights in respect of the visit:

(a) to confer, on request, with an Australian lawyer before it takes place, either in person or by telephone or video link;

(b) to have, on request, a representative, medical practitioner, SMHU staff member or support person present;

(c) to refuse to answer any question that may be put to the patient;

(d) to end the visit at any time.

(5) The visitation of a forensic patient in an SMHU under and in accordance with this section is –

(a) lawful notwithstanding the operation of any other law; and

(b) not reviewable by the Tribunal.

(6) Nothing in this section is to be taken as preventing or restricting police officers from –

(a) exercising ordinary investigative, enforcement or other powers as regards unlawful conduct by forensic patients or other persons in any SMHU; or

(b) exercising, in respect of forensic patients, powers under the *Forensic Procedures Act 2000*; or

(c) doing, in respect of any forensic patient or SMHU, anything else that may be authorised by or under other laws or by any court.

(7) In this section –

responsible authority means –

(a) the controlling authority of the SMHU; or

(b) the CFP.

Division 5 – Telephone calls and mail

106. Patient telephone rights

(1) A forensic patient has, and may exercise subject to and in accordance with this section –

(a) the right to make or refuse to make telephone calls; and

(b) the right to receive or refuse to receive telephone calls.

(2) However, the rights conferred by subsection (1) may be exercised only at reasonable times and intervals determined by a responsible official.

(3) A responsible official may refuse to allow the patient to make or receive telephone calls to or from anyone who is not a privileged caller if –

(a) the responsible official reasonably considers that there are proper grounds to do so; or

(b) in the case of outgoing telephone calls, the responsible official is aware that the intended recipient of the call does not wish to be contacted by the patient; or

(c) in the case of incoming telephone calls, the responsible official is aware that the patient does not wish to be contacted by the caller; or

(d) in the case of incoming calls, they are telemarketing, telepolling or other kinds of nuisance calls.

(4) A responsible official may refuse to allow the patient to make or receive telephone calls to or from a privileged caller if –

(a) in the case of outgoing telephone calls, the responsible official is aware that the intended recipient of the call does not wish to be contacted by the patient; or

(b) in the case of incoming telephone calls, the responsible official is aware that the patient does not wish to be contacted by the caller.

(5) A responsible official may require a person making or wishing to make a telephone call to the patient to provide proof of identity or status and, to avoid doubt, this applies to a privileged caller.

(6) If a person making or wishing to make a telephone call to the patient is not a privileged caller, a responsible official may require the person to –

(a) explain the nature of the person's relationship to the patient; and

(b) explain the purpose of the call; and

(c) provide any other relevant information the responsible official may require.

(7) If subsection (5) or (6) applies, the responsible official may refuse to allow the telephone call to be made or proceed if –

(a) the caller does not comply fully or at all with the requirement; or

(b) the responsible official is not satisfied as to any information provided, whether as to its truth or otherwise.

(8) If the patient makes or receives a telephone call on a reverse charges basis, a responsible official may require the patient to meet those charges.

(9) The rights conferred by subsection (1) do not extend to a right to –

(a) stipulate that any telephone call be made or received via any particular kind or brand of telephone, technology or telecommunications provider; or

(b) have possession of a mobile telephone or other kind of telephonic device or component.

(10) In this section –

telephone call means any communication made by using a telephone, radio or similar electronic device, including a communication consisting of a text message or picture.

Note 1 The exercise of telephone rights under this Subdivision is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

Note 2 The CFP has power to intervene in respect of the exercise of such rights if the CFP is not the relevant decision-maker – see section 147.

107. Patient correspondence rights

(1) A forensic patient in an SMHU has, and may exercise subject to and in accordance with this section –

(a) the right to send or refuse to send mail; and

(b) the right to receive mail or refuse to receive mail.

(2) However, the rights conferred by subsection (1) may be exercised only at reasonable times and intervals determined by a responsible official.

(3) A responsible official may refuse to allow the patient to send or receive mail to or from a person other than a privileged correspondent if –

(a) the responsible official reasonably considers that there are proper grounds to do so; or

(b) in the case of outgoing mail, the responsible official is aware that the addressee does not wish to receive mail from the patient; or

(c) in the case of incoming mail, the responsible official reasonably considers the mail to be promotional, funds touting or any other form of junk mail.

(4) A responsible official may refuse to allow the patient to send or receive mail to or from a privileged correspondent if –

(a) in the case of outgoing mail, the responsible official is aware that the privileged correspondent does not wish to receive mail from the patient; or

(b) in the case of incoming mail, the responsible official is aware that the patient does not wish to receive mail from the privileged correspondent.

(5) A responsible official may require that any mail sent to or received by the patient, other than mail sent to or by a privileged correspondent, be opened and read by an authorised person.

(6) If the patient wishes to send or receive mail for which a charge or fee is payable by the sender or recipient, a responsible official may require the patient to do so at his or her own expense.

(7) The application of this section to mail extends to email but only if the relevant SMHU has that facility.

(8) In this section –

mail includes any part of the mail.

Note 1 The exercise of correspondence rights under this Division is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

Note 2 The CFP has power to intervene in respect of the exercise of such rights if the CFP is not the relevant decision-maker – see section 147.

Division 6 – Further rights, &c.

108. Further rights of forensic patients

Every forensic patient has the following rights:

(a) the right to have the restrictions on, and interference with, his or her dignity, rights and freedoms, kept to a minimum consistent with his or her health or safety and the safety of other persons;

(b) the right to have his or her decision-making capacity promoted, and his or her wishes respected, to the maximum extent consistent with his or her health or safety and the safety of other persons;

(c) the right, while in an SMHU, to have access to current information about local, national and world events;

(d) the right to be given clear, accurate and timely information about –

(i) his or her rights as a forensic patient; and

(ii) the rules and conditions governing his or her conduct in the SMHU; and

(iii) his or her diagnosis and treatment;

(e) the right, while in an SMHU, to apply for leave of absence in accordance with this Act;

(f) the right to be provided with general health care;

(g) the right to be provided with food that is adequate to maintain the health and wellbeing of the patient, and a diet that is not unvarying;

(h) the right to be provided with special dietary food if the CFP is satisfied that

such food is necessary for medical reasons, on account of the patient's religious beliefs or because the patient is a vegetarian;

(i) the right to be provided with basic clean clothing that is suitable for the climate, of suitable size and adequate to maintain the health of the patient;

(j) the right to wear suitable clothing owned by the patient;

(k) the right not to be unreasonably deprived of any necessary physical aids;

(l) the right to adequate toilet and sanitary arrangements;

(m) the right to adequate light and ventilation;

(n) the right to practise a religion of the patient's choice and, if consistent with the management, good order and security of the SMHU, to join with other forensic patients in practising that religion and to possess such articles as are reasonably necessary for the practice of that religion;

(o) the right –

(i) to practise customs in accordance with the patient's cultural beliefs or cultural background; and

(ii) to join with other patients in practising those customs; and

(iii) to possess articles that are reasonably necessary for the practice of those customs –

to the extent that the practice of those customs is not contrary to any law and is consistent with the health and safety of the patient and other patients and the management, good order and security of any approved facility in which the person is present;

(p) the right to have access to legal advice;

(q) the right to be provided with information about the rules and conditions which will govern the patient's behaviour in the SMHU;

(r) the right, while in the SMHU, to ask for and be given such reasonable help from the SMHU staff as will enable the patient to enjoy these rights.

Division 7 – Management, good order and security of secure mental health units

109. Authorisation of persons

(1) The CFP or the controlling authority of an SMHU may authorise a person, or a member of a class of persons, for the purposes of –

(a) section 64; or

(b) any or all of the provisions of this Part; or

(c) any or all of the provisions of Part 4; or

(d) any or all of the provisions of Part 3 of chapter 4; or

(e) any or all of the provisions of Schedule 2 –

as specified in the authorisation.

(2) A reference in a provision of this Act to an authorised person is a reference to a person who is authorised under subsection (1) for the purposes of that provision or the Part containing the provision.

110. Screening of persons seeking entry to SMHU

(1) The CFP may, in relation to an SMHU –

(a) require that any person seeking entry to the SMHU be screened; and

(b) refuse to allow the person into the SMHU if he or she fails to comply with the requirement.

(2) Without limiting the CFP's discretion, a person may be wholly or partially exempted from the screening requirement if the relevant screening devices –

(a) might pose any kind of medical risk to the person; or

(b) might destroy or damage something in the person's possession.

(3) To avoid doubt, medical practitioners, nurses, mental health officers, privileged visitors within the meaning of section 98, police officers, lawyers and SMHU staff members have no immunity from the screening requirement.

(4) Under this section, the controlling authority of the SMHU has the same discretionary powers as the CFP but, in the event of any disagreement between them, the decision of the CFP prevails.

(5) In this section –

screen means a search of a person's body, clothes or belongings conducted by remote or non-intrusive technical devices such as metal detectors, sensors and X-ray scanners or combinations thereof.

111. Searches

(1) The CFP may, in relation to an SMHU, authorise or direct an authorised person to carry out searches for –

(a) the management, good order or security of the SMHU; or

(b) the safety of any persons in the SMHU.

(2) The authorisation or direction constitutes full and sufficient authority for the authorised person to carry out the relevant search, subject to this section, without further formality.

(3) If the authorisation or direction is given orally, it must be confirmed in writing in a CFP approved form.

(4) However, the authorisation or direction cannot apply to privileged visitors unless it is in writing.

(5) The authorisation or direction may do one or more of the following:

(a) be for a specific search or, in the nature of a standing order, for a search to be carried out, either routinely or randomly, at certain times or when certain circumstances apply;

(b) confer related discretions on the authorised person, whether as to timing and search protocol;

(c) provide for the use of specified search equipment or techniques.

(6) A search may be of –

(a) any part of the SMHU; or

(b) anything in the SMHU; or

(c) anything being delivered to or removed from the SMHU or any vehicle, conduit or other thing being used in connection with that delivery or removal; or

(d) any forensic patient, visitor, staff member or other person in the SMHU; or

(e) clothing, personal belongings, physical aids, containers or any other thing in or under the possession or control of a forensic patient, visitor, staff member or other person in the SMHU; or

(f) the information held on a computer, mobile phone or other device.

(7) A search of a person, or of anything in or under a person's possession or control, may be conducted without the person's consent.

(8) If a person other than a forensic patient or SMHU staff member refuses to submit to or hinders a search, an authorised person may direct the person to leave the SMHU forthwith or by a specified time.

(9) A person must comply with a direction under subsection (8).

Penalty: Fine not exceeding 25 penalty units.

(10) If a person refuses or fails to comply with a direction under subsection (8) –

(a) an authorised person may detain the person for such time as is necessary for the person to be arrested by a police officer under paragraph (b); and

(b) a police officer may arrest the person without warrant.

(11) Unless the CFP directs otherwise in a particular case, a search that involves any touching or undressing of a person, or any touching of a person's clothing or personal belongings, must be carried out –

(a) by an authorised person of the same gender as that person and only in the presence of persons of that gender; and

(b) in privacy.

(12) An authorised person who carries out a search may –

(a) use such force, means and assistance as he or she considers reasonably necessary for the purpose; and

(b) ask and require answers to questions as to the source, identity, nature, purpose, properties or contents of anything found.

(13) Under this section, the controlling authority of the SMHU has the same discretionary powers as the CFP but, in the event of any disagreement between them, the decision of the CFP prevails.

(14) In this section –

search means a search carried out by manual, animal detection, electronic or mechanical means, or by any combination of those means;

SMHU includes its immediate precincts.

112. Seizure

(1) An authorised person who is carrying out a search under section 111 may seize any one or more of the following:

(a) anything found (whether in or under a person's possession or control or not) that in the reasonable opinion of the authorised person places, or could place, the management, good order or security of the SMHU or the safety of persons in the SMHU in jeopardy;

(b) anything found on a patient or in or under a patient's possession or control (other than a thing that the patient is authorised to wear or possess or control under this Part, the regulations or CFP standing orders or by the controlling authority);

(c) anything that in the reasonable opinion of the authorised person places, or could place, the management, good order or security of the SMHU or the safety of persons in the SMHU in jeopardy (even if it is something that the patient is authorised to wear or possess or control under this Part, the regulations or CFP standing orders or by the controlling authority).

(2) An authorised person who seizes anything under subsection (1) is to inform the search authority of the seizure forthwith.

(3) The search authority is to ensure that –

(a) anything seized from a visitor or SMHU staff member under this section is returned to that visitor or staff member when he or she leaves the SMHU; or

(b) anything seized from a patient under this section is, on the discharge of the patient from the SMHU, returned to or given into the custody of the patient, the Director, the Secretary (Youth Justice) or the controlling authority of an approved hospital, as appropriate.

(4) However, subsection (3) does not apply if the thing seized is an illicit drug, illicit weapon or other illicit thing.

(5) If the thing seized is an illicit drug, illicit weapon or other illicit thing –

(a) the search authority is to surrender it to the Commissioner of Police; and

(b) the Commissioner of Police may dispose of it as he or she thinks fit.

(6) In this section –

search authority means whichever of the following authorised or directed the relevant search:

(a) the CFP;

(b) the controlling authority of the SMHU.

113. Certain things not to be brought into SMHU

(1) A person must not bring or send into an SMHU anything that the CFP has not authorised to be brought or sent into the SMHU.

Penalty: Fine not exceeding 25 penalty units or imprisonment for a term not exceeding 6 months.

(2) If an SMHU staff member finds a person contravening subsection (1) –

(a) an authorised person may detain the person for such time as is necessary for the person to be arrested by a police officer under paragraph (b); and

(b) a police officer may arrest the person without warrant.

(3) In addition to any other penalty that may be imposed, a person who is convicted of an offence against subsection (1) is not entitled to be employed in or undertake any work, including the practice of medicine, in any SMHU unless the Minister determines otherwise.

(4) In this section –

sending into includes throwing or propelling into or dropping onto.

114. Records, &c.

(1) The controlling authority of an SMHU is to keep appropriate records of the following matters in respect of each forensic patient in the SMHU:

(a) admission and discharge;

(b) the exercise of visitation rights (including any denial or restriction of those rights);

(c) searches, detentions and arrests (whether of visitors or other persons);

(d) seizures of property (whether from the patient or visitors);

(e) police visits;

(f) the exercise of telephone rights (including any denial or restriction of those rights);

(g) the exercise of correspondence rights (including any denial or restriction of those rights).

(2) The controlling authority is to give the Tribunal and the CFP –

(a) at the end of each week, a copy of the records for that week; and

(b) such further information about those records and their content as either of them may subsequently require.

Division 8 – Judicial and related matters

115. Interpretation of Division

In this Division –

judicial officer means a judge, associate judge, magistrate or justice.

116. Bringing patients before courts

(1) If a forensic patient in the custody of the controlling authority of an SMHU is charged with a new offence, a judicial officer may order the controlling authority to bring the patient before the court specified in the order, or the judicial officer who is then present, to be dealt with according to law.

(2) A judicial officer may order the controlling authority of an SMHU to bring a forensic patient in the custody of the controlling authority before the judicial officer to give evidence.

(3) In considering whether to make an order under subsection (1) or (2), and the terms of such an order, a judicial officer is to take into account the advice of the CFP or a medical practitioner as to the fitness of the patient and the impact that such an order is likely to have on the patient's health or safety.

(4) The controlling authority of an SMHU must comply with an order under subsection (1) or (2).

(5) For the purposes of subsection (4) –

(a) the controlling authority of the SMHU may arrange for an MHO, police officer or authorised person to be given a copy of the order and take the patient under escort; and

(b) the custody and escort provisions apply.

(6) Before making an order under subsection (2), a judicial officer may require an applicant to deposit sufficient money to pay all the expenses involved in –

(a) bringing the patient before the court; and

(b) maintaining the patient until he or she is returned to the SMHU.

(7) In this section –

new offence means –

(a) an offence other than the offence which was the cause of a person becoming a prisoner or a youth detainee; or

(b) an offence other than the offence which resulted in a person being detained in an SMHU under an order of a court; or

(c) in the case of an involuntary patient admitted to an SMHU, any offence.

117. Presence at taking of certain depositions

(1) The controlling authority of an SMHU, at the written request of a judicial officer, may allow a forensic patient to leave the SMHU temporarily to attend the taking of a deposition of a person who is dangerously ill and unable to travel.

(2) In considering whether to make a request under subsection (1), and the terms of the request, a judicial officer is to take into account the advice of the CFP or an approved medical practitioner as to the fitness of the patient and the impact that such a request is likely to have on the patient's health or safety.

(3) For the purposes of subsection (1), an authorised person or police officer may –

(a) take the patient under escort; and

(b) remove the patient from the SMHU; and

(c) take the patient to the place specified in the request for the taking of the deposition; and

(d) return the patient to the SMHU.

(4) For the purposes of subsection (3), the custody and escort provisions apply.

118. Court may proceed in absence of forensic patient, &c.

A court may, on the advice of the CFP and despite any other law to the contrary –

(a) hear a matter or otherwise proceed with proceedings before the court in the absence of a forensic patient who is a party to the proceedings if the forensic patient has legal representation; or

(b) hold the hearing or proceedings in any place the court considers appropriate.

119. Notifying victims of final release, &c.

Before a forensic patient is finally released from an SMHU or transferred to another SMHU –

(a) the controlling authority is to notify the Secretary (Corrections) of the impending release or transfer; and

(b) the Secretary (Corrections) is to search the Eligible Persons Register; and

(c) the Secretary (Corrections) is to give each eligible person in relation to the forensic patient notice of the release or transfer, unless circumstances make it impossible or impracticable to give such notice in a particular case.

120. Application of *Corrections Act 1997* to forensic patients who are prisoners

(1) Except as provided in subsection (2), Parts 4, 5, 6, 7 and 9 of the *Corrections Act 1997* do not apply to a forensic patient who is also a prisoner.

(2) Sections 86, 87(1)(b), 87A and 87B of the *Corrections Act 1997* apply to a forensic patient who is also a prisoner.

121. Preservation of royal prerogative of mercy

Nothing in this Act is to be construed so as to limit or affect in any way the exercise, in relation to a forensic patient who is also a prisoner, of the royal prerogative of mercy.

PART 6 – SPECIAL PSYCHIATRIC TREATMENT

122. Meaning of special psychiatric treatment

(1) For the purposes of this Act, *special psychiatric treatment* is –

(a) psychosurgery; or

(b) any treatment that the regulations declare to be special psychiatric treatment.

(2) For the purposes of subsection (1), *psychosurgery* is either of the following procedures:

(a) the use of surgery or intracerebral electrodes to create a lesion in a person's brain with the intention of permanently altering the person's thoughts, emotions or behaviour;

(b) the use of intracerebral electrodes to stimulate a person's brain (without creating a lesion) with the intention of temporarily altering or influencing the person's thoughts, emotions or behaviour.

(3) For the purposes of subsection (2) –

(a) it is irrelevant whether the procedure will, by itself, fully achieve the relevant intention; and

(b) the behaviour referred to is not behaviour that is secondary to epilepsy.

123. Application of Part

This Part applies to all patients and to all voluntary patients.

124. Restriction on provision of special psychiatric treatment

(1) A patient may be given special psychiatric treatment if, and only if –

(a) the treatment has been authorised, beforehand and in writing, by the Tribunal; and

(b) if the treatment is psychosurgery, or a treatment that the regulations specify as a treatment that requires informed consent, informed consent has been given for the treatment.

(2) A person who gives a patient special psychiatric treatment in contravention of subsection (1) is guilty of an offence.

Penalty: Fine not exceeding 1 000 penalty units or imprisonment for a term not exceeding 12 months.

(3) A medical practitioner, nurse or other health professional who gives a patient special

psychiatric treatment otherwise than as provided by subsection (1) is not only guilty of an offence under subsection (2) but is also guilty of professional misconduct of the most serious kind.

125. Clinical restriction on authorisation of special psychiatric treatment

(1) The Tribunal may authorise special psychiatric treatment to be given to a patient if, and only if –

(a) an approved medical practitioner has assessed the patient in the previous 7 days; and

(b) the approved medical practitioner has concluded from the assessment that –

(i) the patient has a mental illness; and

(ii) the mental illness is in general need of treatment; and

(iii) the mental illness is amenable to the special psychiatric treatment; and

(iv) the special psychiatric treatment is, having regard to the patient's condition and treatment history and the risks and benefits of the special psychiatric treatment, a reasonable and appropriate treatment for the patient; and

(v) the treatment is necessary for –

(A) the patient's health or safety; or

(B) the safety of other persons; and

(c) a Chief Psychiatrist and an independent expert, having regard to the nature, quality and results of the assessment, both agree with the approved medical practitioner's conclusions; and

(d) the Tribunal, having regard to the nature, quality and results of the assessment, also agrees with the approved medical practitioner's conclusions; and

(e) the Tribunal is satisfied that appropriate equipment and facilities are available in this State for giving the special psychiatric treatment; and

(f) if the treatment is psychosurgery, or a treatment that is specified in the regulations as one that requires informed consent, the Tribunal is satisfied that informed consent has been given for the treatment.

(2) In this section –

independent expert means a person who –

(a) by virtue of professional qualifications, knowledge or

experience, has expertise directly relevant to the relevant mental illness and its treatment; and

(b) in terms of section 220(1) and (2), has no clear conflict of interest as regards the relevant patient.

126. Procedural restriction on authorisation of special psychiatric treatment

(1) Despite section 125, the Tribunal must not authorise any special psychiatric treatment except –

(a) consequent on a hearing held before at least 3 members; and

(b) on the unanimous affirmative vote of those members, with no proxies or abstentions.

(2) A Tribunal authorisation given contrary to subsection (1) is invalid.

127. Tribunal obligations regarding authorisations

(1) The Tribunal is to ensure that an authorisation of special psychiatric treatment specifies –

(a) the precise nature of the treatment; and

(b) the number of times the treatment may be given; and

(c) the person who (by name or office) may give the treatment; and

(d) when the treatment may be given; and

(e) any special requirements as to method, dosage, frequency, supervision, recovery or other relevant matters.

(2) On authorising any special psychiatric treatment, the Tribunal is to ensure that –

(a) a copy of the authorisation is given to the patient before the treatment commences (together with, depending on the patient's status, a statement of rights in a CCP or CFP approved form); and

(b) a copy of the authorisation is, depending on the patient's status, given to the CCP or CFP.

128. Records, &c.

(1) If a patient is given special psychiatric treatment, the treating medical practitioner is to –

(a) make an appropriate record of the matter; and

(b) place a copy of the record on the patient's clinical record; and

(c) give, at the end of the month in which the treatment is given, a copy of the record to –

(i) the relevant Chief Psychiatrist; and

(ii) the Tribunal.

(2) The Tribunal or relevant Chief Psychiatrist, by notice, may require the treating medical practitioner to provide further information about the special psychiatric treatment within a required time and the treating medical practitioner is to comply with such a requirement.

PART 7 – INFORMATION

129. Statements of rights on admission and discharge

(1) Whenever a person is admitted to an approved facility as a patient, its controlling authority is to give the person a statement of rights in the relevant approved form.

(2) Whenever a patient is discharged from an approved facility, its controlling authority is to give the patient a statement of rights in the relevant approved form.

(3) The obligations of a controlling authority under subsections (1) and (2) are in addition to, not in substitution for, any other obligation that the controlling authority may have under this Act regarding the provision of statements of rights.

(4) In this section –

relevant approved form means –

(a) for an approved assessment centre or approved hospital, a form approved by the CCP; or

(b) for an SMHU, a form approved by the CFP.

130. Notification of certain admissions, transfers and discharges

(1) This section applies if –

(a) a person is, or is going to be, admitted as a patient to an approved hospital or SMHU; or

(b) a patient is, or is going to be, transferred from an approved hospital to –

(i) another approved hospital; or

(ii) an SMHU; or

(c) a patient is, or is going to be, transferred from an SMHU to –

(i) another SMHU; or

(ii) a secure institution; or

(iii) an approved hospital; or

(iv) a health service within the meaning of the *Health Complaints Act 1995*; or

(v) premises where a health service within the meaning of the *Health Complaints Act 1995* is provided; or

(d) a patient is, or is going to be, discharged from an approved hospital, an SMHU, a secure institution, a health service within the meaning of the *Health Complaints Act 1995* or a place from which such a service is provided.

(2) Subject to subsection (3), the controlling authority is to make a reasonable attempt to

notify at least one interested person of the admission, transfer or discharge or, as the case may be, impending admission, transfer or discharge.

(3) However, the notification is not to be given over any objection by the patient unless –

(a) an approved medical practitioner advises the controlling authority that the notification would be desirable having regard to –

(i) the patient's health or safety; or

(ii) the safety of other persons; or

(b) the Tribunal directs the controlling authority to do so.

(4) In the case of an impending admission, transfer or discharge, the notification is to be given as far in advance as practicable.

(5) In this section –

interested person means –

(a) a representative of the patient; or

(b) a support person of the patient; or

(c) any other person who the controlling authority reasonably regards as having a proper interest in the patient's welfare;

patient means, as the context requires, an involuntary patient or forensic patient, and includes a prospective patient.

131. Notification of certain leave and unlawful absences

(1) This section applies if a patient –

(a) is about to take leave of absence from an approved hospital or SHMU; or

(b) has contravened a condition of a leave of absence from an approved hospital or SMHU; or

(c) has absconded from an approved hospital or SMHU.

(2) In a case to which subsection (1)(a) applies where the patient raises no objection, the controlling authority is to make a reasonable attempt to notify (as far in advance as practicable) at least one interested person of the impending leave of absence.

(3) In a case to which subsection (1)(b) or (c) applies, the controlling authority is to make a reasonable attempt to notify at least one interested person of the unlawful absence or contravention.

(4) However, the controlling authority need not comply with this section regarding any matter if the controlling authority has, under another provision of this Act, already given notice of the

same matter to someone who is an interested person within the meaning of this section.

(5) In this section –

abscond means being absent without leave of absence or overstaying a leave of absence;

interested person means –

(a) a representative of the patient; or

(b) a support person of the patient; or

(c) any other person who the controlling authority reasonably regards as having a proper interest in the patient's welfare;

patient means, as the context requires, an involuntary patient or forensic patient.

132. Withholding, &c., of information by mental health authorities

(1) A mental health authority, in giving information to a patient or to any private person about a patient in respect of any matter under this Act, may –

(a) withhold any information; or

(b) defer the giving of any information; or

(c) qualify (but not so as to render it misleading or untruthful) any information.

(2) The withholding, deferral or qualification of the information, if done in good faith, does not constitute –

(a) grounds for any legal proceedings; or

(b) a breach of any clinical guidelines or standing orders; or

(c) in the case of a medical practitioner or other health professional, professional misconduct or a breach of professional ethics.

(3) The mental health authority is to –

(a) place a note about the withholding, deferral or qualification of the information, with reasons, on the patient's clinical record; and

(b) give notice of the withholding, deferral or qualification of the information, with reasons, to the Tribunal; and

(c) give, if the mental health authority is not a Chief Psychiatrist, notice of the withholding, deferral or qualification of the information, with reasons, to the relevant Chief Psychiatrist.

(4) Subsection (1) does not –

(a) authorise a mental health authority to meddle with a copy of an assessment order or treatment order that is required to be given to a patient or other person under a provision of this Act; or

(b) authorise a mental health authority to avoid or defer the making of a determination that it is required to make under this Act; or

(c) authorise a mental health authority to withhold information from a person when seeking, in accordance with the requirements of section 8 or 9, the person's informed consent to a treatment; or

(d) relieve a mental health authority of the obligation to comply fully with –

(i) a subpoena issued by a court or other properly constituted tribunal (including the Tribunal) or by a judicial officer; or

(ii) any other discovery, interrogatory or investigative process sanctioned by or under State or Commonwealth law.

(5) In the event of an inconsistency between this section and another provision of this Act or any instrument made or issued under this Act, this section prevails.

(6) In this section –

information means information that, if disclosed or disclosed fully to the patient either directly or through an intermediary, could reasonably be expected to –

(a) seriously harm the patient's health or safety; or

(b) seriously compromise the patient's care or treatment; or

(c) place the safety of other persons at risk;

meddle, with a copy of an order, means –

(a) destroying or damaging the copy; or

(b) censoring or editing the copy; or

(c) withholding the copy; or

(d) giving the copy to a person later than this Act requires; or

(e) causing one or more of those things to be done;

mental health authority means a Chief Psychiatrist, any controlling authority or an approved medical practitioner;

private person means a person who is not a mental health authority.

Note 1 The withholding, deferral or qualification of information is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

Note 2 The CFP has power to intervene in such circumstances (if the CFP is not the relevant decision-maker) – see section 147.

133. Publication of sensitive information about patients

(1) A person who publishes information for financial or other gain must not –

(a) publish the fact that another person is or has been a patient in an SMHU; or

(b) publish any photograph or other kind of picture of another person, who is or has been a patient in an SMHU, that relates to the person's status as a forensic patient; or

(c) publish any information that could reasonably be expected to identify a person as being or as having been a forensic patient; or

(d) publish any information pertaining to a person's treatment or care as a patient in an SMHU.

Penalty: In the case of –

(a) a body corporate, a fine not exceeding 250 penalty units; or

(b) an individual, a fine not exceeding 50 penalty units or imprisonment for a term not exceeding 6 months.

(2) However, subsection (1) does not apply if the relevant publication is –

(a) expressly and freely authorised by, and with the full understanding of, the person who is or has been an SMHU patient; and

(b) expressly authorised by the CFP.

(3) Also, subsection (1) does not prohibit the publication of a report on any court proceedings which is not otherwise prohibited by or under any law.

(4) In this section –

publish includes, but is not limited to, publish by means of –

(a) a newspaper, magazine or journal; and

(b) a television broadcast; and

(c) a computer.

134. Disclosure of confidential, &c., information about patients

(1) A person who obtains information of a confidential or personal nature about a patient in discharging any responsibilities under this Act must not disclose the information except as authorised or required under subsection (2).

Penalty: Fine not exceeding 50 penalty units or imprisonment for a term not exceeding 6 months.

(2) The information may be disclosed if –

(a) the disclosure is authorised or required by law or any court; or

(b) the disclosure is made for or in connection with the reporting or lawful investigation of a crime or unlawful act (whether actual or prospective); or

(c) where the patient is capable of consenting to the disclosure, the patient so consents; or

(d) despite or regardless of whether the patient consents to the disclosure, the treating medical practitioner considers it necessary for the patient's treatment and care; or

(e) where the patient has been dead for less than 25 years at the relevant time, the patient's next-of-kin consents to the disclosure; or

(f) the disclosure is directly related to the purpose for which the information was obtained and the person making the disclosure reasonably believes that the patient would want or expect the information to be disclosed for that purpose; or

(g) the person making the disclosure reasonably believes it to be necessary so as to prevent or lessen a serious threat to the life, health or safety of the patient or other person; or

(h) the person making the disclosure reasonably believes it to be necessary so as to prevent or lessen a serious threat to public health or safety; or

(i) the disclosure is authorised by the Tribunal; or

(j) the person making the disclosure reasonably believes it to be necessary in connection with the administration of this Act.

135. Translation, interpreters, &c.

All persons exercising responsibilities under this Act are, as far as may be reasonably practicable in the circumstances, to ensure that any information required to be given to a patient or to a representative or support person of a patient is, if necessary through the assistance of an interpreter or an alternative or augmentative communication system, given or relayed in a language or form that the patient or, as the case may be, the representative or support person understands.

136. Monthly reports on voluntary inpatients

(1) The controlling authority of an approved facility is to prepare a monthly report on the accommodation and treatment of long-term voluntary inpatients in that approved facility.

(2) The report is to –

(a) be in an MHT approved form or, as the case may be, CCP approved form; and

(b) specify (at least) –

(i) the name and date of admission of each long-term voluntary inpatient; and

(ii) particulars of the treatment and care given to the long-term voluntary inpatient during the relevant month.

(3) The controlling authority of the approved facility is to give copy of the report to –

(a) the Tribunal; and

(b) the CCP.

(4) For the purposes of subsection (3), the copies of the report are to be given within 14 days after the end of the relevant month.

(5) In this section –

long-term voluntary inpatient, of an approved facility, means a person who has been a

voluntary inpatient of the approved facility for longer than 4 months, continuously, since the date of his or her last admission.

Note The Tribunal may review the status and treatment of any voluntary inpatient – see Division 2 of Part 3 of chapter 3.

137. Parents of child patients to be given same information as patients

(1) A person who is required to give a patient a notice or other document under this Act must, if the patient is a child and the patient does not object, also give a copy of the notice or document to a parent of the patient at the same time.

(2) To avoid doubt, for subsection (1) the giving of the notice or document to one parent is sufficient.

PART 8 – APPROVED PERSONNEL AND FACILITIES

138. Medical practitioners and nurses

(1) A Chief Psychiatrist, by instrument in writing, may approve individual persons (or all members of a class of persons) as medical practitioners for –

(a) provisions of this Act within that Chief Psychiatrist's jurisdiction; and

(b) provisions of any other Act in respect of which that Chief Psychiatrist may have responsibilities.

(2) To be approved as a medical practitioner under subsection (1), or to be a member of a class of persons approved under that subsection, a person must be –

(a) a psychiatrist; or

(b) a medical practitioner who is otherwise qualified or experienced in the diagnosis or treatment of mental illness.

(3) A Chief Psychiatrist, by instrument in writing, may approve individual persons (or all members of a class of persons) as nurses for –

(a) provisions of this Act within that Chief Psychiatrist's jurisdiction; and

(b) provisions of any other Act in respect of which that Chief Psychiatrist may have responsibilities.

(4) To be approved as a nurse under subsection (3), or to be a member of a class of persons to whom the approval relates, a person must be a registered nurse who is qualified or experienced in the treatment or care of persons with mental illness.

(5) An approval is not to be taken for any purpose to constitute a State Service appointment but any State Servant, if appropriately qualified, may hold such an approval (either individually or as a member of a class) in conjunction with State Service employment.

(6) An approval –

(a) takes effect on the day on which it is conferred or on such later day as the relevant Chief Psychiatrist specifies in it; and

(b) unless sooner revoked, remains in effect for 5 years but may from time to time be re-conferred for an equivalent or lesser period.

(7) An individual approval of a person as a medical practitioner is revoked if the person ceases to be –

(a) a psychiatrist; or

(b) a medical practitioner who is otherwise qualified or experienced in the diagnosis or treatment of mental illness.

(8) The revocation of an individual approval of a person under subsection (7) does not prevent a further individual approval being given under subsection (1) if the person becomes a psychiatrist, or a medical practitioner who is otherwise qualified or experienced in the diagnosis or treatment of mental illness.

(9) An individual approval of a person as a medical practitioner is suspended during any period in which his or her registration as a psychiatrist or medical practitioner is suspended under the *Health Practitioner Regulation National Law (Tasmania) Act 2010*.

(10) An individual approval of a person as a nurse is revoked if the person ceases to be a registered nurse who is qualified or experienced in the treatment or care of persons with mental illness.

(11) The revocation of an individual approval of a person under subsection (10) does not prevent a further individual approval being given under subsection (1) if the person becomes a registered nurse who is qualified or experienced in the treatment or care of persons with mental illness.

(12) An individual approval of a person as a registered nurse is suspended during any period in which his or her registration as a nurse is suspended under the *Health Practitioner Regulation National Law (Tasmania) Act 2010*.

(13) In the case of a class approval –

(a) any member of the class ceases to be a member of the class if he or she ceases for any reason to have the characteristics of the class; but

(b) the approval remains in effect as regards the remaining members of the class.

(14) The relevant Chief Psychiatrist, by instrument in writing, may revoke an approval if he or she considers there are other reasonable grounds to do so.

(15) A person, by notice to the relevant Chief Psychiatrist, may relinquish an individual approval at any time.

(16) The relevant Chief Psychiatrist is to publish each approval and each revocation or relinquishment of an approval under this section in –

(a) the *Gazette*; and

(b) such other ways as he or she may consider appropriate.

(17) The relevant Chief Psychiatrist is to notify the Tribunal of each approval and each revocation or relinquishment of an approval under this section.

(18) A Chief Psychiatrist is, by virtue of his or her office, an approved medical practitioner.

139. Mental health officers

(1) A Chief Psychiatrist, by instrument in writing, may approve individual persons (or all members of a class of persons) as mental health officers for –

(a) provisions of this Act within that Chief Psychiatrist's jurisdiction; and

(b) provisions of any other Act in respect of which that Chief Psychiatrist may have responsibilities.

(2) The persons (or, if applicable, each member of the class of persons) so approved must have skills, qualifications or experience relevant to the responsibilities of MHOs under the relevant statutory provisions.

(3) Subject to subsection (2), an approval may be conferred on –

(a) an individual (or class of) State Servant employed in the Department other than an ambulance officer; or

(b) with the consent of the Head of another State Service Agency, an individual (or class of) State Servant employed in that other State Service Agency; or

(c) with the consent of the Director of Ambulance Services under the *Ambulance Service Act 1982*, an individual (or class of) ambulance officer; or

(d) with the consent of the Commissioner of Police, an individual (or class of) police officer; or

(e) another individual (or class of) person.

(4) An approval is not to be taken for any purpose to constitute a State Service or Police Service appointment but –

(a) any State Servant or police officer may hold such an approval (either individually or as a member of a class) in conjunction with State Service or Police Service employment; and

(b) duties that any State Servant or police officer performs as an MHO are taken to be part of his or her duties as a State Servant or police officer.

(5) An approval –

(a) takes effect on the day on which it is conferred or on such later day as the relevant Chief Psychiatrist specifies in it; and

(b) unless sooner revoked, remains in effect for 5 years but may from time to time be re-conferred for an equivalent or lesser period.

(6) The relevant Chief Psychiatrist, by instrument in writing, may revoke an approval if he or she considers there are reasonable grounds to do so.

(7) An individual person, by notice to the relevant Chief Psychiatrist, may relinquish an approval at any time.

(8) In the case of a class approval –

(a) any member of the class ceases to be a member of the class if he or she ceases for any reason to have the characteristics of the class; but

(b) the approval remains in effect as regards the remaining members of the class.

(9) The relevant Chief Psychiatrist is to publish each approval and each revocation or relinquishment of an approval in the *Gazette* and in such other ways as he or she may consider appropriate.

(10) The relevant Chief Psychiatrist is to notify the Tribunal of each approval and each revocation or relinquishment of an approval.

(11) The relevant Chief Psychiatrist –

(a) is to issue each MHO who is not a police officer or ambulance officer with an identity card which shows that he or she has that status and which the MHO may use and, if necessary, produce whenever acting in that capacity; and

(b) may issue such an identity card to each MHO who is a police officer or ambulance officer.

(12) If a person ceases to be an MHO, the relevant Chief Psychiatrist is to retrieve the person's identity card, if issued.

(13) A Chief Psychiatrist has, by virtue of his or her office, all the powers and functions of an MHO within that Chief Psychiatrist's jurisdiction.

140. Hospitals and other facilities

(1) The Minister, by notice in the *Gazette*, may approve premises as –

(a) hospitals for this Act; or

(b) assessment centres for this Act; or

(c) secure mental health units for this Act.

(2) The approval may be conferred –

(a) for government premises, on the Minister's own motion; and

(b) for non-government premises, on the application, or with the agreement, of the prospective controlling authority.

(3) However, the Minister is not to confer the approval unless satisfied that the relevant premises are properly built, equipped and staffed to, as the case requires, assess or treat –

(a) for an approval under subsection (1)(a) or (b), involuntary patients with mental illness; and

(b) for an approval under subsection (1)(c), forensic patients.

(4) Also, the Minister is not to confer the approval on non-government premises unless satisfied that the prospective controlling authority is a suitable body or person to be in charge of an approved facility of the relevant kind.

(5) The approval may be conferred –

(a) conditionally or unconditionally; or

(b) for a fixed or indeterminate period.

(6) The approval may be in such form as the Minister thinks fit but should at least specify –

(a) which premises are approved; and

(b) the kind of approved facility; and

(c) for non-government premises, the controlling authority; and

(d) when the approval takes effect; and

(e) when, if applicable, the approval expires if not sooner revoked.

(7) Unless the relevant approval provides otherwise, an approved hospital is taken to also be an approved assessment centre.

141. Secure institutions

The Minister, by instrument in writing, may approve an institution, other than an approved facility, as a secure institution.

142. Revocation of approvals for hospitals and other facilities

(1) The Minister, by notice in the *Gazette*, may revoke an approval under section 140 if satisfied that –

(a) the relevant premises are no longer suitable for use as such an approved facility; or

(b) the controlling authority (or a prospective new controlling authority) is not a suitable body or person to be in charge of such an approved facility; or

(c) standing orders, clinical guidelines or MHT guidelines are being materially or repeatedly contravened at the approved facility; or

(d) the relevant premises are no longer being used as an approved facility; or

(e) the relevant premises have been destroyed or damaged (other than superficially) by fire or other natural causes; or

(f) the relevant premises have been or are to be demolished (with or without any intention to rebuild); or

(g) the controlling authority or owner (or a prospective new controlling authority or owner) proposes to put the premises to different use; or

(h) there are other reasonable grounds for the revocation.

(2) The Minister is not to revoke a declaration relating to non-government premises unless the Minister has –

(a) notified the controlling authority and given it a reasonable opportunity to make representations on the proposed revocation; and

(b) considered any such representations.

(3) However, subsection (2) does not apply if –

(a) the Minister is satisfied that the approved facility has already been demolished or destroyed; or

(b) the controlling authority has requested the revocation.

(4) A notice under subsection (1) is to specify when the revocation takes effect.

(5) When the revocation takes effect, the relevant premises cease to be, as the case may be, an

approved hospital, approved assessment centre or SMHU.

CHAPTER 3 – OVERSIGHT AND REVIEW

PART 1 – CHIEF PSYCHIATRISTS

Division 1 – Appointment

143. Chief Civil Psychiatrist

(1) The Governor may appoint a person to be Chief Civil Psychiatrist.

(2) The appointee must be a psychiatrist with at least 5 years' experience in practising psychiatry.

(3) The office of Chief Civil Psychiatrist may be held in conjunction with State Service employment.

(4) The Chief Civil Psychiatrist has a general overall responsibility, under and to the Minister, for ensuring that the objects of this Act are met in respect of –

(a) patients other than –

(i) forensic patients; or

(ii) persons who are subject to supervision orders; and

(b) the running of approved facilities other than secure mental health units.

144. Chief Forensic Psychiatrist

(1) The Governor may appoint a person to be Chief Forensic Psychiatrist.

(2) The appointee must be a psychiatrist with at least 5 years' experience in practising psychiatry.

(3) The office of Chief Forensic Psychiatrist may be held in conjunction with State Service employment.

(4) The Chief Forensic Psychiatrist has a general overall responsibility, under and to the Minister, for ensuring that the objects of this Act are met in respect of –

(a) forensic patients and persons who admitted to an SMHU under section 63; and

(b) persons who are subject to supervision orders; and

(c) the running of secure mental health units.

Division 2 – Features of office

145. Term of office

A Chief Psychiatrist –

(a) holds office for such term not exceeding 5 years as is specified in his or her instrument of appointment; and

(b) may, if eligible, be reappointed.

146. Functions and powers

(1) A Chief Psychiatrist has the functions given to that Chief Psychiatrist by this or any other Act.

(2) A Chief Psychiatrist has –

(a) power to do anything necessary or convenient to be done to perform his or her functions; and

(b) such other powers as are expressly or impliedly given to that Chief Psychiatrist by this or any other Act.

(3) Without limiting subsection (2) –

(a) either Chief Psychiatrist may approve forms for use under provisions of this Act within his or her jurisdiction or under provisions of other Acts in respect of which he or she may have responsibilities; and

(b) the Chief Forensic Psychiatrist may authorise a person or class of persons for the purposes of Part 4 of chapter 2 or any provision of that Part.

147. Power of direct intervention

(1) A Chief Psychiatrist has, in prescribed matters within his or her jurisdiction, the power to intervene directly with regard to the assessment, treatment and care of any patient.

Note The exercise of a Chief Psychiatrist's power of intervention is reviewable by the Tribunal – see Division 2 of Part 3 of chapter 3.

(2) The power of intervention is exercisable –

(a) on the Chief Psychiatrist's own motion; or

(b) at the request of the patient; or

(c) at the request of any person who, in the opinion of the Chief Psychiatrist, has a proper interest in the patient's health, safety or welfare.

(3) However, the power of intervention is only exercisable if the Chief Psychiatrist –

(a) has made inquiries into the relevant prescribed matter; and

(b) is satisfied from those inquiries that intervention is essential to the patient's health, safety or welfare.

(4) The power of intervention is exercisable by giving any person responsible for the treatment and care of the patient, as regards the relevant prescribed matter, a notice to do one or more of the following:

(a) discontinue or alter a particular practice, procedure or treatment in respect of the patient;

(b) observe or carry out a particular practice, procedure or treatment in respect of the patient.

(5) The Chief Psychiatrist, by the same or a different notice, may also do either or both of the following:

(a) issue consequential directions for the future assessment, treatment or care of the patient;

(b) direct that any decision triggering or relating to the intervention be referred, by a specified person, to the Tribunal for review within a specified time.

Note For the review of such decisions by the Tribunal – see Division 2 of Part 3 of chapter 3.

(6) Nothing in this section is to be taken as authorising a Chief Psychiatrist to issue directions that are repugnant to –

(a) any provision of this Act; or

(b) a provision of any other Act; or

(c) an order, determination or direction of the Tribunal or any court.

(7) A failure by an individual to comply with a direction contained in a notice issued by a Chief Psychiatrist under this section is not an offence but does constitute proper grounds for instituting professional or, as the case may be, occupational disciplinary action against that individual.

(8) In this section –

prescribed matters means the following:

(a) the use of seclusion;

(b) the use of restraint;

(c) the use of force;

(d) the granting, refusal and control of leaves of absence;

(e) the giving or withholding of patient information;

(f) the granting, denial and control of visiting, correspondence and telephone rights;

(g) assessment and treatment generally;

(h) matters prescribed by the regulations.

148. Independence

Notwithstanding the *State Service Act 2000*, in acting or forming any opinion in clinical matters a Chief Psychiatrist is not subject to the direction of the Minister, the other Chief Psychiatrist or any other person.

149. Delegation

(1) A Chief Psychiatrist may delegate any of his or her powers or functions under this or any other Act other than –

(a) this power of delegation; and

(b) the power to issue, vary or revoke clinical guidelines and standing orders; and

(c) any powers or functions under Part 6 of chapter 2.

(2) However, under subsection (1), a restricted professional power, or a function necessary or incidental to the exercise of a restricted professional power, must not be delegated to anyone other than a medical practitioner.

(3) In this section –

restricted professional power means a power to –

(a) authorise the giving of urgent circumstances treatment; or

(b) authorise seclusion or restraint, or an extension of a period of seclusion or restraint, under section 56 or 57 or section 94 or 95; or

(c) direct under section 59 or Division 3 of Part 4 of chapter 2 the transfer of patients to secure

institutions, approved hospitals, a health service within the meaning of the *Health Complaints Act 1995* or premises where such a service is provided; or

(d) make a decision about admitting an involuntary patient to, or detaining an involuntary patient at, an SMHU under section 63 or 64; or

(e) make a decision about the transfer of a prisoner or a detainee to an SMHU pursuant to section 36A(2) or (3) of the *Corrections Act 1997* or section 134A(2) or (3) of the *Youth Justice Act 1997*; or

(f) make a decision under section 70 to return a person to the custody of a responsible authority; or

(g) make a decision under Division 5 or 6 of Part 4 of chapter 2.

150. Reporting

(1) A Chief Psychiatrist, before 30 September after each financial year, is to give the Minister a report on the Chief Psychiatrist's activities during that financial year.

(2) The Minister may direct the Chief Psychiatrist to prepare the report in a particular style or format or to include particular information in the report.

(3) The Minister is to cause a copy of the report to be laid before each House of Parliament within 10 sitting-days of that House after receiving the report.

Division 3 – Clinical guidelines and standing orders

151. Clinical guidelines

(1) A Chief Psychiatrist may issue guidelines (*clinical guidelines*) to help controlling authorities, medical practitioners, nurses or other persons in the exercise of their responsibilities in respect of any treatment, clinical procedure or other clinical matter under –

(a) provisions of this Act within that Chief Psychiatrist's jurisdiction; or

(b) provisions of other Acts in respect of which that Chief Psychiatrist may have responsibilities.

(2) Without limiting the generality of subsection (1), the clinical guidelines may indicate how a provision of this or another Act ought to be applied in a practical clinical or forensic setting.

(3) To avoid doubt, the specific mention of clinical guidelines in certain provisions of this or another Act does not preclude them from being issued and applied to other provisions of the same Act

where they are not mentioned if the relevant Chief Psychiatrist considers there is a proper basis for doing so.

(4) A person exercising, under this or another Act, responsibilities in respect of a matter for which clinical guidelines have been issued is to have regard to those clinical guidelines.

(5) A failure by an individual to have regard to clinical guidelines is not an offence but may, particularly if it leads to unfavourable patient outcomes that might otherwise have been avoided or if there is a history of such disregard, constitute proper grounds for instituting professional or, as the case may be, occupational disciplinary action against that individual.

152. Standing orders

(1) A Chief Psychiatrist may issue directions (standing orders) to controlling authorities, medical practitioners, nurses or other persons regarding the exercise of their responsibilities in respect of any clinical or non-clinical procedure or matter under –

(a) provisions of this Act within that Chief Psychiatrist's jurisdiction; and

(b) provisions of other Acts in respect of which that Chief Psychiatrist may have responsibilities.

Note The CCP must, however, ensure that there are standing orders in relation to the restraint of involuntary patients – see section 57(5).

(2) Without limiting the generality of subsection (1), the standing orders may indicate how a provision of this or another Act ought to be applied in a practical clinical or forensic setting.

(3) To avoid doubt, the specific mention of standing orders in certain provisions of this or another Act does not preclude them from being issued and applied to other provisions where they are not mentioned if the relevant Chief Psychiatrist considers there are reasonable grounds to do so.

(4) A person exercising, under this or another Act, responsibilities in respect of a matter for which standing orders have been issued must comply with those standing orders.

(5) A failure by an individual to comply with standing orders is not an offence but does constitute proper grounds for instituting professional or, as the case may be, occupational disciplinary action against that individual.

153. Matters common to clinical guidelines and standing orders

(1) Clinical guidelines and standing orders –

(a) are to be written in plain language with a minimum of technical and professional jargon; and

(b) are to be as brief as possible consistent with their intended application; and

(c) are to clearly state which legislative provisions they relate to; and

(d) are to follow a standard style and format; and

(e) may be made so as to apply differently according to such matters, limitations or restrictions, whether as to time, location, circumstance or otherwise, as are specified in them; and

(f) may confer responsibilities and discretionary responsibilities on persons (including the Chief Psychiatrist issuing them) and provide for the delegation of those responsibilities; and

(g) may not purport to impose fines or other penalties for any failure to comply with them; and

(h) may not contain provisions that are repugnant to the other provisions of this or any other Act; and

(i) may not purport to authorise anyone to disregard or act contrary to a judicial order.

(2) In the event that the provisions of any clinical guidelines or standing orders are inconsistent with the provisions of any Act, the provisions of the Act always prevail.

(3) To avoid overlap, ambiguity or inconsistency, the CCP and CFP are to liaise with the Tribunal and each other when drafting any clinical guidelines or standing orders.

(4) Clinical guidelines and standing orders are to be published, in the manner the Chief Psychiatrist issuing them considers necessary or desirable having regard to their intended application.

(5) No fee is chargeable or payable for issuing, supplying or obtaining a copy of any clinical guidelines or standing orders.

(6) A Chief Psychiatrist is to give the Tribunal a copy of any issued or draft clinical guidelines or standing orders on request.

(7) Clinical guidelines and standing orders are not –

(a) statutory rules; or

(b) instruments of a legislative character for the purposes of the *Subordinate Legislation Act 1992*.

(8) To avoid doubt, clinical guidelines and standing orders are instruments to which section 22 of the *Acts Interpretation Act 1931* applies.

PART 2 – OFFICIAL VISITORS

Division 1 – Preliminary

154. Interpretation of Part

In this Part, unless the contrary intention appears, a reference to an Official Visitor is taken to include a reference to the Principal Official Visitor.

Division 2 – Appointment, functions and powers

155. Appointment

(1) The Governor, on the recommendation of the Minister, may appoint a Principal Official Visitor.

(2) The Principal Official Visitor may appoint one or more Official Visitors.

(3) A person cannot be appointed under subsection (1) or (2) if he or she –

(a) holds another appointment of any kind under this Act; or

(b) holds an approval of any kind under this Act; or

(c) has, either directly or indirectly, an interest in any contract with the State or Commonwealth Crown related in any way to an approved facility or the

provision of mental health services, which interest may prevent, or could reasonably be perceived as likely to prevent, the person from acting impartially as an Official Visitor; or

(d) is, either directly or indirectly, a party to a contract with an approved facility or its controlling authority; or

(e) has, either directly or indirectly, a financial interest in an approved facility; or

(f) has, either directly or indirectly, an interest in the land on which an approved facility, or premises from which a person is provided with services under this Act, is built; or

(g) is a State Servant, or other person, employed in the responsible Department in relation to the *Health Act 1997* or, if another Act is prescribed for the purposes of this paragraph, that other Act.

(4) Schedule 5 has effect in respect of Official Visitors.

156. Functions of Principal Official Visitor

(1) The Principal Official Visitor has the following functions:

(a) to arrange for Official Visitors to visit approved facilities and any premises from which patients are provided with services under this Act;

(b) to receive complaints from (or concerning) patients, including complaints referred to the Principal Official Visitor by Official Visitors;

(c) to assess and conduct preliminary enquiries into complaints received from (or concerning) patients, including complaints referred to the Principal Official Visitor by Official Visitors;

(d) to refer suspected contraventions of this Act, or other matters that may require investigation, to the Health Complaints Commissioner or Ombudsman;

(e) to promote, amongst patients and administrators and in other relevant quarters, an awareness of Official Visitors and their role;

(f) to report on suspected contraventions of this Act or standing orders or clinical guidelines;

(g) to report on the extent to which the objects of this Act and the mental health service delivery principles are being met;

(h) to raise with the Minister for Health or relevant Chief Psychiatrist any matters of

particular concern that come to the Principal Official Visitor's attention;

(i) to perform such other functions as are conferred on the Principal Official Visitor under this or any other Act.

(2) Subject to this Part, the Principal Official Visitor may determine the manner in which Official Visitors are to perform their functions.

(3) For the purposes of subsection (2), the Principal Official Visitor may issue a code of conduct, and from time to time amend or replace that code.

(4) A code of conduct is not a statutory rule.

(5) Except to such extent as the provisions of section 157 otherwise indicate, the Principal Official Visitor may perform any function of an Official Visitor.

157. Functions of Official Visitors

Any Official Visitor has the following functions:

(a) to visit, in accordance with the arrangements made by the Principal Official Visitor, approved facilities and premises from which patients are provided with services under this Act; and

(b) to receive complaints from (or concerning) patients;

(c) to refer complaints received from (or concerning) patients to the Principal Official Visitor;

(d) to report suspected contraventions of this Act, or other matters that may require investigation, to the Principal Official Visitor;

(e) to check that patients are being informed of and accorded their rights;

(f) to monitor the adequacy and quality of approved facilities, with particular regard to the recreational, occupational, training and rehabilitation facilities available to patients;

(g) to raise with the Principal Official Visitor any matters of particular concern that come to the Official Visitor's attention;

(h) to perform such other functions as are conferred on the Official Visitor under this or any other Act.

158. Delegation

(1) The Principal Official Visitor may delegate any of his or her functions to an Official Visitor.

(2) If the delegate under subsection (1) is a State Servant, he or she may perform the delegated functions in conjunction with State Service employment.

(3) The power of delegation under subsection (1) cannot itself be delegated.

159. Powers of Official Visitors

(1) The Principal Official Visitor has the power to do all things necessary or convenient to be done to perform his or her functions.

(2) An Official Visitor has the power to do all things necessary or convenient to be done to perform his or her functions.

(3) The delegation of a function under section 158 also confers on the delegate power to do all things necessary or convenient to be done to perform that function.

Division 3 – Visits and complaints

160. Visits

(1) The Principal Official Visitor must arrange for each approved facility to be visited by an Official Visitor at least once a month.

(2) The Principal Official Visitor must arrange for an Official Visitor to visit premises in or from which a patient is being provided with services under this Act if requested to do so by –

(a) the patient; or

(b) a representative or support person of the patient; or

(c) a person who, in the opinion of the Principal Official Visitor, has a genuine interest in the patient's welfare; or

(d) the Minister for Health.

(3) The Principal Official Visitor is not obliged to comply with subsection (2)(a) in respect of any premises if –

(a) those premises have been visited by an Official Visitor in the month immediately preceding the making of the relevant request; or

(b) the Principal Official Visitor considers the relevant request to be frivolous or vexatious.

(4) A visit under this section may be made with or without notice.

(5) A visit to an SMHU under this section is subject to statutory or other reasonable requirements relating to the management, good order and discipline of the SMHU.

161. Complaints

(1) Any patient is entitled to make a complaint to an Official Visitor.

(2) An Official Visitor may also accept a complaint, concerning any patient, from –

(a) a support person, or representative, of the patient; or

(b) a person who, in the opinion of the Official Visitor, has a genuine interest in the patient's welfare.

(3) A complaint may be made by any available means acceptable to the Official Visitor concerned.

Division 4 – Miscellaneous

162. Independence

An Official Visitor, in performing his or her functions and exercising related powers and forming related opinions –

(a) must act independently, impartially and in the public interest; and

(b) must have regard to the objects of this Act and the mental health service delivery principles.

163. Obligation of officials to assist Official Visitors, &c.

(1) All persons discharging responsibilities under this Act must give patients such reasonable help as they may require in making complaints under this Part.

(2) Specifically, if a patient expresses to a person discharging responsibilities under this Act a wish

to see or complain to an Official Visitor, the person must inform an Official Visitor of that wish within 24 hours.

(3) Additionally, if a person discharging responsibilities under this Act knows that a patient has expressed a wish to see or complain to an Official Visitor, the person must, to the maximum extent of the person's lawful and physical capacity to do so –

(a) grant Official Visitors access to those parts of premises in which the patient is being accommodated or being assessed or treated; and

(b) facilitate private and direct communication between Official Visitors and the patient (consistently with the patient's wishes); and

(c) grant Official Visitors access to records relating to the patient's assessment, treatment and care, including clinical records (unless the patient has asked that Official Visitors not be granted that access); and

(d) grant Official Visitors access to other relevant records or registers required to be kept under this Act; and

(e) answer questions about the assessment, treatment and care of the patient to the best of the person's knowledge and in a full and frank manner (unless the patient

has asked that Official Visitors not be provided with that information); and

(f) give Official Visitors such other reasonable assistance as they may require.

(4) To avoid doubt, nothing in this section is to be taken as compelling any patient to –

(a) see, speak to or complain to an Official Visitor against the patient's will; or

(b) grant an Official Visitor access to any record concerning the patient.

(5) In this section –

wish, of a patient, includes a wish expressed by a representative or support person of the patient on his or her behalf.

164. Identification

(1) The Secretary is to issue the Principal Official Visitor with an identity card.

(2) The Principal Official Visitor is to issue each Official Visitor with an identity card.

(3) An Official Visitor's identity card is to be in a form approved by the Secretary but it must contain at least the name and signature, and a recent photograph, of the person to whom it is issued.

(4) An Official Visitor, when performing his or her functions –

(a) must display his or her identity card at all times; and

(b) must allow any patient, controlling authority or Chief Psychiatrist to inspect the identity card on demand.

(5) When a person ceases for any reason to hold the office of Principal Official Visitor, the Secretary is to take reasonable measures to retrieve the person's identity card or ensure that it has been properly disposed of.

(6) When a person ceases for any reason to hold the office of Official Visitor, the Principal Official Visitor is to take reasonable measures to retrieve the person's identity card or ensure that it has been properly disposed of.

Division 5 – Reporting

165. Operational and monthly reporting, &c.

(1) If the Principal Official Visitor knows or reasonably suspects that this Act has been contravened in any material way, he or she is to report the matter to the Health Complaints Commissioner or Ombudsman (whichever seems more appropriate in the circumstances).

(2) At any time, the Principal Official Visitor may give the Minister for Health or a Chief Psychiatrist a private report on any matter

related to the responsibilities or activities of Official Visitors.

(3) The Principal Official Visitor is to –

(a) give the Minister for Health, after the end of each quarter of a calendar year, a written report on the activities of Official Visitors during the quarter; and

(b) give the Minister for Health such further or additional reports on matters of special concern related to Official Visitor functions as the Minister may request.

(4) The Principal Official Visitor is to give a copy of a report prepared under subsection (3) to –

(a) the relevant Chief Psychiatrist; and

(b) the controlling authority of the relevant facility or the person in charge of the premises from which the relevant services are being provided under this Act.

166. Annual report

(1) The Principal Official Visitor, before 30 September after the end of each financial year, is to give the Minister for Health a report on the activities of Official Visitors during that financial year.

(2) The Minister for Health may direct the Principal Official Visitor to prepare the report in a

particular way or include particular information in the report.

(3) The Minister for Health is to cause a copy of the report to be laid before each House of Parliament within 10 sitting-days of that House after receiving the report.

PART 3 – MENTAL HEALTH TRIBUNAL

Division 1 – Administrative

167. Establishment

(1) The Mental Health Tribunal is established.

(2) The Tribunal consists of –

(a) at least one person who is an Australian lawyer with at least 5 years' experience as such; and

(b) at least one person who is a psychiatrist; and

(c) at least 4 other members.

(3) The members are appointed by the Governor.

(4) The Governor may appoint one of the members referred to in subsection (2)(a) as the President of the Tribunal.

(5) The Governor may appoint one of the members referred to in subsection (2)(b) or (c) as Deputy President of the Tribunal.

(6) Schedule 3 has effect in respect of the membership of the Tribunal.

(7) Schedule 4 has effect in respect of the proceedings of the Tribunal.

(8) Except as otherwise provided by this Act, the Tribunal may regulate its own proceedings.

168. Functions

(1) The Tribunal has the following functions:

(a) to make, vary, renew and discharge treatment orders;

(b) to authorise the treatment of forensic patients;

(c) to authorise special psychiatric treatment;

(d) to determine applications for leave, from secure mental health units, for patients subject to restriction orders;

(e) to carry out any further functions given to it under this or any other Act.

(2) The Tribunal also has the review function set out in Division 2.

169. Powers

(1) The Tribunal has –

(a) power to do all things necessary or convenient to be done to perform its functions; and

(b) such other powers as it is given by this or any other Act.

(2) Without limiting subsection (1), the Tribunal may –

(a) issue guidelines (*MHT guidelines*) on matters within its jurisdiction; and

(b) require reports from any person on patients or matters within its jurisdiction; and

(c) approve forms for use in connection with matters within its jurisdiction.

(3) Subsections (1), (2), (5), (6), (7) and (8) of section 153 apply, with any necessary modification, to MHT guidelines.

(4) A failure by an individual to comply with MHT guidelines is not an offence but does constitute proper grounds for instituting professional or, as the case may be, occupational disciplinary action.

170. Divisions

(1) The Tribunal may sit in divisions.

(2) A division consists of one member, or 3 or more members, chosen by the President to constitute the division for a particular case or class of cases.

(3) The President may constitute or be a member of any division.

(4) In choosing the member or members to constitute any division of the Tribunal, the President is to have regard to –

(a) the nature of the matters to be considered by the division; and

(b) the need for the member or members of the division to have appropriate knowledge and experience.

(5) The President is to ensure that any division of 3 or more members has at least –

(a) one member who is an Australian lawyer; and

(b) one member who is a psychiatrist.

(6) If a division consists of 3 or more members –

(a) its chairperson, if the President is a member, is the President; or

(b) its chairperson, if the President is not a member –

(i) is the member of the division who is an Australian lawyer; or

(ii) is, if there is more than one member of the division who is an Australian lawyer, the one of those members appointed as chairperson by the President.

171. Acting by majority

If the Tribunal is constituted of 3 or more members, then, except as this Act otherwise requires –

(a) it may proceed with the hearing and determination of proceedings in the absence of one member; and

(b) a decision in which the majority of the members agree is a decision of the Tribunal.

Note The authorisation of special psychiatric treatment is an exception to this – see section 126.

172. Interim determinations on adjournment

(1) The Tribunal may adjourn proceedings, but not more than twice, and only if the total period of all such adjournments together is not more than 30 days.

(2) On adjourning any proceedings, the Tribunal may make any interim orders or determinations it considers appropriate in the circumstances.

(3) An interim order or determination has effect for the period of the adjournment and any subsequent adjournment.

(4) This section does not prevent the Tribunal from varying or revoking an interim order or determination or from making a further interim

order or determination on any subsequent adjournment.

(5) To avoid doubt, the Tribunal's power under this section extends, in relevant proceedings, to –

(a) the making or renewal, on an interim basis, of treatment orders; and

(b) the authorisation, on an interim basis, of the treatment of forensic patients; and

(c) the authorisation, on an interim basis, of special psychiatric treatment; and

(d) the authorisation, on an interim basis, of patient leaves of absence.

173. Questions of law

The Tribunal may state in the form of a special case for determination by the Supreme Court any question of law that may arise in the hearing or determination of any proceedings.

174. Appeals from determinations

(1) A person who is a party to any proceedings of the Tribunal may appeal to the Supreme Court from any determination made in those proceedings.

(2) A person may appeal to the Supreme Court if the person is aggrieved by any determination of the Tribunal made otherwise than in proceedings.

(3) An appeal may be brought –

(a) on a question of law, as of right; or

(b) on any other question, only with the leave of the Supreme Court.

175. Appeals procedure

(1) An appeal under section 174 is to be instituted in accordance with the rules in force under the *Supreme Court Civil Procedure Act 1932* –

(a) within 30 days after the day on which the appellant is given notice of the relevant determination by the Tribunal; or

(b) if, within the period referred to in paragraph (a), the person gives the Tribunal a written request for a statement of reasons for the relevant determination, within 30 days after the day on which the person is given that statement of reasons.

(2) Notwithstanding subsection (1), the Supreme Court may at any time allow an appeal to be brought later than that subsection allows.

(3) The Supreme Court is to hear and determine the appeal and may make an order –

(a) affirming the determination; or

(b) setting aside the determination and substituting its own determination; or

(c) setting aside the determination and remitting the matter to the Tribunal for redetermination, with or without directions.

(4) The Supreme Court may make any further order it considers just in the circumstances.

176. Registrar and staff

(1) The Secretary is to appoint a State Servant employed in the Department to be Registrar of the Tribunal and that State Servant may hold that office in conjunction with State Service employment.

(2) The Tribunal may make arrangements with the Secretary for the services of such other State Servants employed in the Department to be made available to the Tribunal as will enable it to exercise and perform its powers and functions.

(3) A State Servant may, pursuant to subsection (1) or (2), serve the Tribunal in conjunction with State Service employment, but when so serving is subject to the direction of the President of the Tribunal in matters concerning this Act or an Act referred to in section 179.

177. Register

The Registrar is to keep a register of –

(a) applications made to the Tribunal; and

(b) Tribunal determinations.

178. Annual report

(1) The Tribunal, before 30 September after the end of each financial year, is to give the Minister a report on its activities during that year.

(2) The Minister is to cause a copy of the report to be laid before each House of Parliament within 10 sitting-days of that House after receiving the report.

Division 2 – Reviews

179. The Tribunal's review function

(1) The Tribunal is to review, in accordance with this Division –

(a) the making of assessment orders; and

(b) treatment orders (and their variation and discharge); and

(c) admissions of involuntary patients to SMHUs; and

(d) the status of voluntary inpatients; and

(e) the placement of any involuntary patient or forensic patient under seclusion or restraint; and

(f) the application of force to any forensic patient; and

(g) the withholding, from any patient, of information by persons; and

(h) the transfer of any involuntary patient or forensic patient within Tasmania; and

(i) the granting, refusal, cancellation or variation of leave of absence for any involuntary patient or forensic patient who is not subject to a restriction order; and

(j) the exercise of visiting, correspondence or telephone rights by any forensic patient.

(2) The Tribunal is also required to review –

(a) as provided by section 36B of the *Corrections Act 1997*, admissions of prisoners to secure mental health units; and

(b) as provided by section 134B of the *Youth Justice Act 1997*, admissions of youth detainees to secure mental health units; and

(c) as provided by section 37 of the *Criminal Justice (Mental Impairment) Act 1999*, restriction orders or supervision orders made under that Act.

(3) The Tribunal may also review –

(a) CFP refusals, under section 70, to return forensic patients to the custody of the Director or the Secretary (Youth Justice); and

(b) the giving of urgent circumstances treatment to any involuntary or forensic patient; and

(c) the exercise of a Chief Psychiatrist's power of direct intervention; and

(d) any matter referred to it by, or at the direction or instigation of, a Chief Psychiatrist; and

(e) any matter prescribed by the regulations.

180. Review of assessment order

The following provisions govern the review of the making of an assessment order:

(a) the Tribunal may review the making of the order at any time –

(i) on its own motion; or

(ii) on the application of any person with the necessary standing;

(b) the Tribunal may review the making of the order even if it is no longer in effect;

(c) the Tribunal may also review the making of any other assessment order,

concerning the same patient, at the same time;

(d) on review, the Tribunal may affirm the order or, if it is still in effect, discharge the order;

(e) the Tribunal is to –

(i) give a copy of its determination to the patient (together with a statement of rights in an MHT approved form); and

(ii) give a copy of its determination to the CCP; and

(iii) if the order is still in effect and requires the patient's admission to an approved facility, give a copy of the determination to the controlling authority.

181. Review of treatment order

(1) The following provisions govern the review of a treatment order:

(a) the Tribunal must review the order within 30 days after it is made if it is still in effect;

(b) the Tribunal must further review the order within 90 days after it is made if it is still in effect;

(c) after the further review referred to in paragraph (b), the Tribunal must further review the order at intervals not exceeding 90 days for so long as it remains in effect;

(d) the Tribunal must review the order within 3 days after being notified of the patient's detention at an approved hospital pursuant to section 42(3);

(e) the Tribunal may review the order at any other time –

(i) on its own motion; or

(ii) on the application of any person with the necessary standing;

(f) a review is to be conducted by a division of 3 members but need not involve a hearing;

(g) on review, the Tribunal may affirm, vary or discharge the order.

(2) The Tribunal may vary a treatment order at any time –

(a) on its own motion; or

(b) on the application of any approved medical practitioner; or

(c) on the application of any person with the necessary standing.

(3) Within 24 hours of varying a treatment order, the Tribunal is to –

(a) give a copy of its determination to the patient (together with a statement of rights in an MHT approved form); and

(b) give a copy of its determination to –

(i) if the order has required or will require the patient's admission to an approved hospital, the controlling authority of that approved hospital; and

(ii) if the patient is also a forensic patient, the CFP and the controlling authority of the relevant SMHU; and

(iii) in any other case, the CCP.

(4) The Tribunal is not to vary a treatment order so as to require a patient who is a child to be detained in an approved hospital unless it is satisfied that the approved hospital –

(a) has adequate facilities and staff for the appropriate treatment and care of the patient; and

(b) is, in the circumstances, the most appropriate place available to detain the patient.

182. Review of involuntary admission to SMHU

The following provisions govern the review of the admission (or any extension of the admission) of an involuntary patient to an SMHU:

(a) the Tribunal must review the admission (or extension) within 3 days after being notified of the admission (or extension);

(b) the Tribunal may review the admission (or extension) at any other time –

(i) on its own motion; or

(ii) on the application of any person with the necessary standing;

(c) on review, the Tribunal may –

(i) affirm the admission (or extension); or

(ii) affirm the admission (or extension) but direct that it be shortened; or

(iii) direct that the patient be transferred to an approved hospital or, if the Tribunal considers that the patient is well enough to be released directly into the community, another place.

183. Review of refusal to return forensic patient to external custodian

The following provisions govern the review of a CFP refusal under section 70:

(a) the Tribunal may review the refusal –

(i) on its own motion at any time; or

(ii) on the application of any person with the necessary standing;

(b) if paragraph (a)(ii) applies, the review is to be done within 7 days after the application is made;

(c) on review, the Tribunal may –

(i) affirm the refusal; or

(ii) set aside the refusal;

(d) if the refusal is set aside, section 70(8) applies to the patient as if the CFP had agreed to the patient's request on the day the CFP was notified of the Tribunal's determination.

184. Review of status of voluntary inpatient

The following provisions govern the review of the status of a voluntary inpatient:

(a) the Tribunal must review the patient's status once he or she has been a

voluntary inpatient for 6 continuous months;

(b) the review must be commenced within 30 days after the 6-month period expires;

(c) after the review, the Tribunal must review the patient's status at intervals not exceeding 6 months for as long as he or she remains a voluntary inpatient;

(d) the Tribunal may review the patient's status at any other time –

(i) on its own motion; or

(ii) on the application of any person with the necessary standing;

(e) on review, the Tribunal may do either or both of the following:

(i) affirm the patient's status;

(ii) direct the controlling authority of the approved facility where the patient is being accommodated to arrange for an approved medical practitioner to apply for a treatment order in respect of the patient.

185. Review of admission to SMHU of prisoner or youth detainee

The following provisions govern the review of the admission of a forensic patient to an SMHU pursuant to section 68(1)(i) and (j):

(a) the Tribunal must review the admission within 7 days after being notified of the admission;

(b) the Tribunal may review the admission at any other time –

(i) on its own motion; or

(ii) on the application of any person with the necessary standing;

(c) on review, the Tribunal may –

(i) affirm the admission; or

(ii) recommend that consideration be given to returning the patient to prison or a detention centre; or

(iii) direct that the patient be discharged from the SMHU and returned to prison or a detention centre.

186. Review of urgent circumstances treatment

(1) The following provisions govern the review of urgent circumstances treatment:

(a) the Tribunal may do the review at any time –

(i) on its own motion; or

(ii) on the application of any person with the necessary standing;

(b) the Tribunal may do the review even if the treatment has ceased;

(c) on review, the Tribunal may –

(i) in the case of an involuntary patient not subject to a treatment order, recommend that the patient be examined against the treatment criteria to see whether or not a treatment order needs to be made; or

(ii) in the case of an involuntary patient subject to a treatment order, recommend that the patient be examined to determine whether an application needs to be made to have the treatment order varied; or

(iii) in the case of a forensic patient, recommend that an approved medical practitioner seek the Tribunal's authorisation of treatment in respect of the patient; or

(iv) set aside an authorisation under section 55 or section 87;

(d) on review, the Tribunal may also do either or both of the following:

(i) seek additional information from the relevant Chief Psychiatrist or approved medical practitioner (for example, a report about the efficacy of the treatment);

(ii) recommend that the relevant Chief Psychiatrist exercise any of his or her powers under this Act consequent on or in connection with the treatment.

(2) The Tribunal's power under subsection (1)(a)(i) applies not only to specific instances of urgent circumstances treatment but also to any group of such treatments jointly, whether of the same patient or different patients.

(3) The provisions of paragraphs (c) and (d) of subsection (1) apply, with any necessary modification, to a review of the kind referred to in subsection (2).

187. Review of seclusion and restraint

The following provisions govern the review of any instance of seclusion or restraint:

(a) the Tribunal may do the review on its own motion at any time;

(b) the Tribunal must do the review on the application of any person with the necessary standing;

(c) the Tribunal may do the review even if the period of seclusion or restraint has ended;

(d) on review, the Tribunal may –

(i) affirm the use of the seclusion or restraint; or

(ii) direct that the seclusion or restraint be terminated or suspended forthwith or by a specified time (if it is ongoing); or

(iii) declare that the patient should not have been subjected to the seclusion or restraint, either at all or in the way it was.

188. Review of force

The following provisions govern the review of the application of force to a forensic patient:

(a) the Tribunal may do the review on its own motion at any time;

(b) the Tribunal must do the review on the application of any person with the necessary standing;

(c) the Tribunal may do the review even if the application of force has ended;

(d) on review, the Tribunal may –

(i) affirm the application of force; or

(ii) declare that force should not have been applied to the patient, either at all or in the way it was.

189. Review of withholding of information from patient

The following provisions govern the review of the withholding by persons of information from a patient:

(a) the Tribunal may do the review on its own motion at any time;

(b) the Tribunal must do the review on the application of any person with the necessary standing;

(c) on review, the Tribunal may –

(i) affirm the decision to withhold the information; or

(ii) set aside the decision to withhold the information;

(d) if the decision is set aside, the Tribunal may –

(i) substitute its own decision for the one set aside; or

(ii) remit the matter to the decision-maker, with or without directions, for redetermination.

190. Review of involuntary patient or forensic patient transfer within Tasmania

The following provisions govern the review of the transfer within Tasmania of an involuntary patient or a forensic patient:

(a) the Tribunal may do the review on its own motion at any time;

(b) the Tribunal must do the review on the application of any person with the necessary standing;

(c) on review, the Tribunal may –

(i) affirm the decision to transfer the patient; or

(ii) set aside the decision to transfer the patient;

(d) if the decision is set aside, the Tribunal may –

(i) substitute its own decision for the one set aside; or

(ii) remit the matter to the decision-maker, with or without directions, for redetermination.

191. Review of determination relating to leave of absence

The following provisions govern the review of the grant, refusal or variation of a leave of absence (*leave*) to an involuntary patient, or to a forensic patient who is not subject to a restriction order:

(a) the Tribunal may do the review on its own motion at any time;

(b) the Tribunal must do the review on the application of any person with the necessary standing;

(c) the review may be done whether or not the leave is prospective or, if applicable, has commenced or concluded or been varied;

(d) on review, the Tribunal may –

(i) affirm the decision to grant, refuse or vary the leave; or

(ii) set aside the decision to grant, refuse or vary the leave;

(e) if the relevant decision is set aside, the Tribunal may –

(i) substitute its own decision for the one set aside; or

(ii) remit the matter to the decision-maker, with or without directions, for redetermination;

(f) nothing in this section is to be taken as authorising the Tribunal, on review, to –

(i) grant an involuntary patient a discrete period of leave exceeding 14 days; or

(ii) direct that an involuntary patient be granted a discrete period of leave exceeding 14 days.

192. Review of exercise of visiting, telephone or correspondence right

The following provisions govern the review of a decision concerning a forensic patient's visiting, telephone or correspondence rights:

(a) the Tribunal may do the review on its own motion at any time;

(b) the Tribunal must do the review on the application of any person with the necessary standing;

(c) the review may be done whether or not the relevant rights have been exercised;

(d) on review, the Tribunal may –

(i) affirm the relevant decision; or

(ii) set aside the relevant decision;

(e) if the relevant decision is set aside, the Tribunal may –

(i) substitute its own decision for the one set aside; or

(ii) remit the matter to the decision-maker, with or without directions, for redetermination.

193. Other reviews

The following provisions govern the review of any decision (or matter) for which express provision is not otherwise made in this Division:

(a) the Tribunal may do the review –

(i) on its own motion at any time; or

(ii) on the application of any person with the necessary standing;

(b) on review, the Tribunal may –

(i) affirm the relevant decision; or

(ii) set aside the relevant decision or action taken;

(c) if the relevant decision is set aside, the Tribunal may –

(i) substitute its own decision for the one set aside; or

(ii) remit the matter to the decision-maker, with or without directions, for redetermination.

194. General powers, &c., on review

The following provisions govern the conduct of any review:

(a) the Tribunal may combine a mandatory review with a discretionary review;

(b) the Tribunal may refer any matter concerning the review to the relevant Chief Psychiatrist for possible intervention;

(c) the Tribunal, in making a determination, may issue any related or incidental directions it considers appropriate and, without limiting this, may –

(i) direct that the patient be examined or given specified health care; and

(ii) direct a specified person to provide the Tribunal or another person with a specified report at or by a specified time; and

(iii) direct that a specified action be taken or not taken in respect of the patient; and

(iv) give directions to ensure and monitor compliance with its determination; and

(v) direct that the patient or another person be given a statement of rights;

(d) the Tribunal may give a copy of its determination to any health professional or other person who, to its knowledge, is directly involved with the patient's treatment or care;

(e) the Tribunal may issue such recommendations to such persons as it considers appropriate.

195. Form of applications for review, &c.

(1) An application to the Tribunal (whether for a review or any other matter) is to –

(a) be in an MHT approved form; and

(b) identify the patient and the applicant (if not the patient); and

(c) identify the patient's representatives and support persons; and

(d) state the grounds for seeking the review or, as the case may be, making the application; and

(e) be lodged with the Registrar; and

(f) be supported by such evidence or information as the Tribunal requires,

either at the time of lodgement or subsequently; and

(g) provide for any matter required by the regulations; and

(h) be accompanied by any material required by the regulations.

(2) The Registrar may help any person make an application.

(3) The controlling authority of an approved facility is to ensure that –

(a) patients in the approved facility are given reasonable help in making applications; and

(b) without limiting this, lawyers, advocates, translators or other persons on whose skills a patient in the approved facility may need to rely in that regard are afforded reasonable access to the patient.

(4) An application may be withdrawn at any time.

196. Refusal of review

(1) The Tribunal may refuse to review any matter on application if –

(a) it has concluded a review of the same matter within the preceding 3 months; or

(b) there is nothing in the application to indicate that there has been any material change in the relevant circumstances since the previous review.

(2) To avoid doubt, subsection (1) prevails over any other provision of this Part.

197. On-paper reviews by Registrar

(1) The President may authorise the Registrar to review any matter or class of matters if satisfied that –

(a) no hearing is required; and

(b) it is within the Registrar's competence to do such a review.

(2) A Registrar's review done with the President's authority is as valid and effectual as if it had been done by the Tribunal.

(3) Section 167(8) extends to the Registrar's review.

(4) This section does not apply to a 30-day or 90-day review of a treatment order.

198. Preliminary evaluation

(1) The President may direct the Registrar or an MHT staff member to –

(a) do a preliminary evaluation of any application; and

(b) report to the Tribunal accordingly.

(2) Without limiting subsection (1), the preliminary evaluation may extend to provisionally assessing the merits of the application, provisionally checking any claims or facts and ascertaining whether the application has any particular urgency or special features or is likely to require a hearing.

(3) The preliminary evaluation does not bind the Tribunal in any way.

(4) Section 167(8) extends to the preliminary evaluation and report.

(5) Despite the direction under subsection (1), the Registrar or MHT staff member may remit the matter to the President at any time (or seek directions) if the Registrar or staff member reasonably considers that –

(a) the matter may be beyond the Registrar's or MHT staff member's competence; or

(b) a hearing may be required; or

(c) it may not, for some other reason, be an appropriate matter for preliminary evaluation.

Division 3 – Determinations

199. Evidence of Tribunal determination

(1) A determination of the Tribunal must be signed by –

(a) a member involved in making the determination; or

(b) the Registrar.

(2) All courts and persons acting judicially must take judicial notice of the signature of any person who is or has been the President, the Deputy President, the Registrar or a member of the Tribunal and of the fact that that person is or was the President, Deputy President, the Registrar or a member, as the case may be.

(3) In any proceedings, a document purporting to be signed by the President or Deputy President and to be a copy of a determination made by the Tribunal under this Act is evidence of the determination.

CHAPTER 4 – INTERGOVERNMENTAL AGREEMENTS

PART 1 – PRELIMINARY

200. Interpretation of Chapter

In this Chapter –

abscond means being absent without leave of absence or overstaying a leave of absence;

corresponding law means a law of another State providing for the treatment and care of persons with mental illness;

eligible patient means –

(a) an involuntary patient; or

(b) a forensic patient; or

(c) a person who is subject to a supervision order;

forensic patient does not include a forensic patient who is a prisoner;

involuntary patient, for Part 3, includes –

(a) a person who is subject to a continuing care order under the *Criminal Justice (Mental Impairment) Act 1999*; and

(b) a person who is subject to an assessment order or continuing care order under the *Sentencing Act 1997*;

mental health facility means any place for the treatment and care of persons with mental illness;

reciprocating State, for an agreement under this Part, means the State that Tasmania has the agreement with.

201. Power of Minister to enter into interstate agreements

(1) The Minister, on behalf of Tasmania, may –

(a) enter into interstate transfer agreements and interstate control agreements; and

(b) from time to time amend any such agreement.

(2) The Minister is to give notice in the *Gazette* of the making or amendment of an interstate transfer agreement or interstate control agreement together with a general summary or indication of what the agreement or amendment provides for.

(3) An interstate transfer agreement or interstate control agreement may provide for incidental matters such as the transfer and registration of relevant orders and the transfer of clinical notes and other relevant materials.

(4) Nothing in this section limits the power of the State to –

(a) enter into other intergovernmental agreements in relation to mental health matters; or

(b) publish in full the text of any intergovernmental agreement it may enter into.

PART 2 – INTERSTATE TRANSFER AGREEMENTS

202. Nature of interstate transfer agreements

An interstate transfer agreement is an agreement, between the Minister and the Minister's counterpart in another State, providing for the interstate transfer on humanitarian grounds of eligible patients or any class of eligible patients.

203. Operation of interstate transfer agreements

If an interstate transfer agreement so provides, then, subject to and in accordance with its terms –

(a) an eligible patient who is required to be detained may be transferred from an approved hospital or SMHU in Tasmania to a mental health facility in the reciprocating State; and

(b) an eligible patient who is required to be detained may be transferred from a mental health facility in the reciprocating State to an approved hospital or SMHU in Tasmania; and

(c) any order under a law of the reciprocating State that corresponds to a treatment order authorising a patient's treatment has effect in Tasmania (with any adaptation or modification provided for by the agreement) as if it were a

treatment order in the same or substantially the same terms as the order under the law of the reciprocating State; and

(d) any order under a law of the reciprocating State that corresponds to a supervision order has effect in Tasmania (with any adaptation and modification provided for by the agreement) as if it were an order of that kind in the same or substantially the same terms as those of the order under the law of the reciprocating State; and

(e) the supervision of a person who is subject to a Tasmanian supervision order may be transferred from the CFP to a medical practitioner in the reciprocating State.

204. Effect of certain transfers

On a transfer mentioned in section 203(b), an order for a person's detention under a law of the reciprocating State has effect in Tasmania (with any adaptation and modification provided for by the interstate transfer agreement) as if it were –

(a) in the case of an involuntary patient, an assessment order or treatment order made under this Act or an order made pursuant to section 72 or 75 of the *Sentencing Act 1997*, specifying an approved hospital as the assessment or treatment setting; and

(b) in the case of a forensic patient in respect of whom an SMHU has been specified as the appropriate assessment or treatment setting –

(i) a restriction order or continuing care order under the *Criminal Justice (Mental Impairment) Act 1999* or *Sentencing Act 1997*; or

(ii) an assessment order made pursuant to section 72 of the *Sentencing Act 1997*.

PART 3 – INTERSTATE CONTROL AGREEMENTS

205. Nature of interstate control agreements

An interstate control agreement is an agreement, between the Minister and the Minister's counterpart in another State, providing for either or both of the following:

(a) the apprehension, detention and return of any one or more of the following:

(i) involuntary patients or forensic patients who abscond from the approved hospital or SMHU where they are being lawfully detained and are found at large in the reciprocating State;

(ii) persons who are liable to be detained in an SMHU as forensic patients and who are liable to be detained in an approved hospital as involuntary patients and are found at large in the reciprocating State;

(iii) persons who are in breach of supervision orders and are found at large in the reciprocating State;

(iv) involuntary patients who are in breach of treatment orders and are found at large in the reciprocating State;

(b) the apprehension, detention and return of any one or more of the following:

(i) persons, other than prisoners, who abscond from the mental health facility where they are being detained under a law of the reciprocating State and are found at large in Tasmania;

(ii) persons, other than prisoners, who are liable to be detained in a mental health facility under a law of the reciprocating State and are found at large in Tasmania;

(iii) persons who are in breach of orders made under a law of the reciprocating State providing for their treatment in a community setting (including any orders of that kind that correspond to supervision orders) and are found at large in Tasmania.

206. Power of Tasmanian officials to act under corresponding law

Subject to the terms of any relevant interstate control agreement, an MHO or authorised person may discharge any responsibilities conferred on the MHO or authorised person (or on MHOs or authorised persons or any category of MHOs or authorised persons collectively) under a corresponding law.

207. Power of interstate officials to act in Tasmania

Subject to the terms of any relevant interstate control agreement, a person who is authorised to discharge any responsibilities under a corresponding law may also discharge those responsibilities in Tasmania.

208. Apprehension, &c., of involuntary patients, &c., from interstate

(1) This section applies if, during the term of an interstate control agreement, a person –

(a) absconds from the mental health facility where he or she is being detained under a law of the reciprocating State and, not being a prisoner of the reciprocating State, is found at large in Tasmania; or

(b) is liable to be detained in a mental health facility under a law of the reciprocating State and, not being a prisoner of the reciprocating State, is found at large in Tasmania; or

(c) is in breach of an order made under a law of the reciprocating State providing for the person's treatment in a community setting (including any order of that kind that corresponds to a supervision order) and is found at large in Tasmania.

(2) The person may be apprehended by –

(a) an MHO, authorised person or police officer; or

(b) anyone who, under a law of the reciprocating State, would be authorised to apprehend the person had he or she been found at large in that State.

(3) For the purposes of subsection (2), a warrant or other instrument that, under a law of the reciprocating State, would authorise the apprehension of the person if he or she were found at large in that State also authorises the person's apprehension in Tasmania.

(4) On being apprehended, the person –

(a) is to be escorted to a mental health facility of the reciprocating State; but

(b) may be escorted to, admitted to and detained in an approved hospital or SMHU in Tasmania pending his or her return to that State.

(5) For the purpose of apprehending the person –

(a) an MHO or police officer may exercise any powers that he or she may exercise under Part 2 of chapter 2 (and Schedule 2) in relation to persons being taken into protective custody; and

(b) an authorised person has all the powers of an MHO; and

(c) anyone acting under subsection (2)(b) has all the powers of an MHO.

209. Apprehension, &c., of involuntary patients, &c., found interstate

(1) This section applies if, during the term of an interstate control agreement, any of the following is found at large in the reciprocating State:

(a) an involuntary patient or forensic patient who has absconded from the approved hospital or SMHU where he or she is being detained;

(b) a person who is liable to be admitted to and detained in an SMHU or approved hospital as an involuntary patient or a forensic patient;

(c) a person who is in breach of a treatment order authorising the person's treatment in a community setting.

(2) The patient or person found at large in the reciprocating State may be apprehended and, as the case may be, escorted to the approved hospital or SMHU by –

(a) an MHO, authorised person or police officer; or

(b) anyone who, under a law of the reciprocating State, is authorised to

escort the patient or person to a mental health facility in that State.

210. Apprehension of persons under supervision orders found interstate

(1) This section applies if, during the term of an interstate control agreement, a person in breach of a supervision order is found at large in the reciprocating State.

(2) The person may be apprehended and returned to Tasmania and placed back under the supervision of the CFP by –

(a) an MHO, authorised person or police officer; or

(b) anyone who, under a law of the reciprocating State, is authorised to apprehend persons in breach of orders of that State that correspond to supervision orders.

CHAPTER 5 – MISCELLANEOUS

PART 1 – GENERAL

211. Remote medical procedures

(1) For the purposes of this Act, a medical procedure may be carried out in person or by any available technical means sanctioned by or consistent with –

(a) the operational protocols of the facility from or in which the procedure is carried out; or

(b) any clinical guidelines; or

(c) any standing orders.

(2) In this section –

medical procedure includes assessment, examination, diagnosis and treatment;

technical means includes video conferencing.

212. Special powers of ambulance officer acting as MHO

(1) An approved ambulance officer, when acting as an MHO in transporting any patient by ambulance under this Act, may sedate the patient if the approved ambulance officer reasonably considers it necessary or prudent to do so, having regard to, and in accordance with, any

field protocols approved under the *Poisons Act 1971* by the Director, within the meaning of the *Ambulance Service Act 1982*.

(2) Nothing in this section is to be taken as authorising an approved ambulance officer to sedate a patient contrary to the *Poisons Act 1971* or another law of the State.

(3) An approved ambulance officer who exercises the power of sedation under subsection (1) is to give the CCP a report of the matter.

(4) The report is to –

(a) be in a CCP approved form; and

(b) be given within 14 days after the end of the month in which the power of sedation is exercised; and

(c) set out full particulars of the matter, including –

(i) the name of the patient; and

(ii) the reason for the transportation; and

(iii) particulars of the sedation, the reasons for it, and the outcome.

(5) In this section –

approved ambulance officer means an ambulance officer who is approved as an MHO for this Act;

patient includes a prospective patient;

transport includes –

(a) helping to transport; and

(b) making preparations to transport.

PART 2 – OFFENCES

213. Unlawful treatment

(1) A person must not give a patient an unlawful treatment.

Penalty: Fine not exceeding 100 penalty units or imprisonment for a term not exceeding one year.

(2) For the purposes of subsection (1), a treatment is unlawful if it is given without informed consent or, in the absence of informed consent, authorisation under this Act.

214. Obstruction of persons discharging responsibilities under Act, &c.

(1) A person must not obstruct or hinder an MHA official or MHA entity in the discharge of any responsibilities under this Act.

Penalty: Fine not exceeding 25 penalty units or imprisonment for a term not exceeding 6 months.

(2) In this section –

MHA entity means the Tribunal or the controlling authority of an approved facility;

MHA official means –

(a) an approved medical practitioner; or

(b) an approved nurse; or

(c) an authorised person; or

(d) a Chief Psychiatrist; or

(e) a member of the Tribunal; or

(f) an MHO; or

(g) the Principal Official Visitor or an Official Visitor; or

(h) the Registrar or an MHT staff member.

215. Contravention of Tribunal determinations

A person must not contravene a determination or direction of the Tribunal.

Penalty: Fine not exceeding 25 penalty units or imprisonment for a term not exceeding 6 months.

216. False or misleading statements

A person must not, in giving any information under this Act –

(a) make a statement knowing it to be false or misleading; or

(b) omit any matter from a statement knowing that without the matter the statement is false or misleading.

Penalty: Fine not exceeding 25 penalty units.

PART 3 – LEGAL AND ADMINISTRATIVE

217. Immunities

(1) An MHA official does not incur any personal liability for any act done or purported or omitted to be done in good faith in the discharge of the MHA official's responsibilities under this or any other Act.

(2) A liability that, but for this section, would attach to an MHA official attaches to the employer of the official.

(3) No civil or criminal proceedings lie against any person for anything done in good faith and with reasonable care in reliance on any order or document apparently given or made in accordance with the requirements of this Act.

(4) In this section –

MHA official means –

(a) an approved medical practitioner; or

(b) an approved nurse; or

(c) an authorised person; or

(d) a Chief Psychiatrist; or

(e) a member of the Tribunal; or

(f) an MHO; or

(g) the Principal Official Visitor or an Official Visitor; or

(h) the Registrar or an MHT staff member.

218. Delegation by Minister

The Minister may delegate any of his or her responsibilities under this Act other than –

(a) this power of delegation; or

(b) powers under section 140 or 142.

219. Delegation by controlling authority

The controlling authority of an approved facility may delegate any of the controlling authority's responsibilities under this Act other than this power of delegation.

220. Conflicts of interest

(1) A person must not discharge a responsibility in respect of a patient under this Act if the person has a clear conflict of interest.

(2) For the purposes of subsection (1), a person has a clear conflict of interest if he or she knows or reasonably ought to know that the discharge of the responsibility could, whether on account of an interest in a facility used in the patient's

treatment or otherwise, confer a direct or indirect financial benefit on the person or a close associate of the person.

(3) For a health professional, a contravention of subsection (1) constitutes professional misconduct of the most serious kind unless the health professional concerned establishes that –

(a) by reason of an emergency or other special circumstances, the health professional had no reasonable option but to discharge the responsibility for the patient's immediate health or safety or for the immediate protection of others; or

(b) the Tribunal or a Chief Psychiatrist, after being informed by the health professional of the potential for a conflict of interest, sanctioned in advance the discharge of the responsibility.

(4) For the purposes of this section, a person is taken to be a close associate of another person (an *MHA provider*) if the first-mentioned person is –

(a) a proprietary company in which the MHA provider is a shareholder; or

(b) a public company in which the MHA provider is directly or indirectly a substantial shareholder; or

(c) a beneficiary under a trust or an object of a discretionary trust of which the MHA provider is a trustee; or

(d) a business or commercial partner of the MHA provider; or

(e) the employer or an employee of the MHA provider; or

(f) a person from whom the MHA provider has received, or might reasonably be expected to receive, a fee, commission or other reward for providing professional or other services; or

(g) the spouse or partner of the MHA provider; or

(h) the son, daughter, brother, sister, mother or father of the MHA provider or their spouse or partner.

(5) In this section –

financial benefit does not include the receipt of a salary or professional fees;

partner means partner within the meaning of the *Relationships Act 2003*;

patient includes a prospective patient.

221. Defects in appointments, &c.

(1) An appointment, approval, authorisation or delegation under this Act is not invalid merely because of a technical defect in relation to the appointment, approval, authorisation or delegation.

(2) Nothing done by a person holding an appointment, approval, authorisation or delegation under this Act is invalid merely because of a technical defect in relation to the appointment, approval, authorisation or delegation.

(3) In this section –

technical defect means a defect or irregularity of form or process.

222. Errors affecting orders

(1) The validity of an order under this Act is not affected by an error unless –

(a) the error relates to the grounds on which the order was made and proper grounds for making it did not exist; or

(b) as a result of the error, the order does not comply with a mandatory requirement of this Act relating to the making of the order.

(2) An error in an order under this Act that does not affect its validity may be corrected by the person or persons who made it.

223. Status of notices

Unless otherwise expressly provided, a notice under this Act is not –

(a) a statutory rule; or

(b) an instrument of a legislative character for the purposes of the *Subordinate Legislation Act 1992*.

224. Service of documents

A notice or other document is effectively served under this Act if –

(a) in the case of a natural person, it is –

(i) given to the person; or

(ii) left at, or sent by post to, the person's postal or residential address or place or address of business or employment last known to the server of the notice or other document; or

(iii) faxed to the person's fax number; or

(iv) emailed to the person's email address; and

(b) in the case of any other person, it is –

(i) left at, or sent by post to, the person's principal or registered office or principal place of business; or

(ii) faxed to the person's fax number; or

(iii) emailed to the person's email address.

225. Regulations

(1) The Governor may make regulations for the purposes of this Act.

(2) Without limiting subsection (1), the regulations may further control and regulate the provision of special psychiatric treatment.

(3) The regulations may be made so as to apply differently according to matters, limitations or restrictions, whether as to time, circumstance or otherwise, specified in the regulations.

(4) The regulations may authorise any matter to be from time to time determined, applied, approved or regulated by the Minister, a Chief Psychiatrist or the Tribunal.

226. Amendment of Schedule 1

(1) The Governor, by order, may amend Schedule 1 at any time by –

(a) adding provisions of any kind to the Schedule; or

(b) omitting provisions of any kind from the Schedule; or

(c) substituting provisions of any kind of the Schedule; or

(d) doing any combination of those things.

(2) An order under subsection (1) is not an instrument of a legislative character for the purposes of the *Subordinate Legislation Act 1992*.

(3) The provisions of sections 47(3), (3A), (4), (5), (6) and (7) of the *Acts Interpretation Act 1931* apply to an order under subsection (1) as if the order were regulations within the meaning of that Act.

227. Administration of Act

Until provision is made in relation to this Act by order under section 4 of the *Administrative Arrangements Act 1990* –

(a) the administration of this Act is assigned to the Minister for Health; and

(b) the department responsible to that Minster in relation to the administration of this Act is the Department of Health and Human Services.

228. Legislation repealed

The legislation specified in Schedule 6 is repealed.

229. Legislation rescinded

The legislation specified in Schedule 7 is rescinded.

SCHEDULE 1 – MENTAL HEALTH SERVICE DELIVERY PRINCIPLES

Section 15, section 156, section 162 and section 226

1. The mental health service delivery principles are as follows:

(a) to respect, observe and promote the inherent rights, liberty, dignity, autonomy and self-respect of persons with mental illness;

(b) to interfere with or restrict the rights of persons with mental illness in the least restrictive way and to the least extent consistent with the protection of those persons, the protection of the public and the proper delivery of the relevant service;

(c) to provide a service that is comprehensive, accessible, inclusive, equitable and free from stigma;

(d) to be sensitive and responsive to individual needs (whether as to culture, language, age, religion, gender or other factors);

(e) to emphasise and value promotion, prevention and early detection and intervention;

(f) to seek to bring about the best therapeutic outcomes and promote patient recovery;

(g) to provide services that are consistent with patient treatment plans;

(h) to recognise the difficulty, importance and value of the role played by families, and support persons, of persons with mental illness;

(i) to recognise, observe and promote the rights, welfare and safety of the children and other dependants of persons with mental illness;

(j) to promote the ability of persons with mental illness to make their own choices;

(k) to involve persons receiving services, and where appropriate their families and support persons, in decision-making;

(l) to recognise families, and support persons, of persons with mental illness as partners, with mental health service providers, in the provision of their treatment and care to the extent that this is appropriate and consistent with their own wishes;

(m) to respect the wishes of persons receiving services, and the wishes of their families and support persons, to the maximum extent consistent with the health and

safety of those persons and the safety of others;

(n) to promote and enable persons with mental illness to live, work and participate in their own community;

(o) to operate so as to raise community awareness and understanding of mental illness and to foster community-wide respect for the inherent rights, liberty, dignity, autonomy and self-respect of persons with mental illness;

(p) to be accountable;

(q) to recognise and be responsive to national and international clinical, technical and human rights trends, developments and advances.

SCHEDULE 2 – CUSTODY AND ESCORT PROVISIONS

Sections 17(2), 31(2), 46(2), 59(6), 61(4), 60(7), 64(9), section 72(6), section 73(5), section 75(3), 78(10), 79(9), 82(11), 83(7), 116(5) and 117(4)

PART 1 – PRELIMINARY

1. Interpretation

In this Schedule –

custodian or *escort*, of a patient, means a police officer, MHO or authorised person who, by or under this Act, is empowered or authorised to take the patient into protective custody or under escort;

frisk search, of a patient, means a search conducted speedily by any or any combination of the following means:

(a) running the hands over the patient's outer clothing;

(b) passing a metal detection device over or in close proximity to the patient's outer clothing;

(c) examining anything worn or carried by the patient that he or she appears to have removed or discarded voluntarily;

(d) passing a metal detection device over or in close proximity to anything worn or carried by the patient that he or she appears to have removed or discarded voluntarily;

ordinary search, of a patient, means a search limited to –

(a) requiring in the searcher's discretion, the patient to remove, one or more of the following:

(i) any coat, jacket or like outer garment;

(ii) any hat;

(iii) any shoes, boots or like footwear;

(iv) any socks;

(v) any gloves or mittens;

(vi) any handbag, backpack or like carrying item; and

(b) requiring, in the searcher's discretion, the patient to empty all or any of his or her pockets; and

(c) examining the item or items so removed and the contents thereof and, if applicable, the contents of the pockets so emptied;

patient includes a prospective patient;

relevant advice or direction, includes advice or direction from –

(a) the Commissioner of Police or another commissioned police officer within the meaning of the *Police Service Act 2003*; or

(b) a Chief Psychiatrist; or

(c) a medical practitioner; or

(d) the Director of Ambulance Services under the *Ambulance Service Act 1982*.

take, a patient into protective custody or under escort, includes holding the patient in protective custody or under escort.

PART 2 – POWERS AND DUTIES

1. General powers, &c., of custodians and escorts

To take a patient into protective custody or under escort –

(a) the custodian or escort may enlist the assistance of any person, including, if necessary, a police officer; and

(b) the custodian or escort (and any assistant) may use reasonable force against the patient if he or she resists

being taken into protective custody or under escort; and

(c) the custodian or escort (and any assistant) may use reasonable force against anyone who may try to prevent the patient from being taken into protective custody or under escort; and

(d) the custodian or escort (if necessary with any assistant) may, without warrant and doing as little damage as possible, enter any premises if the custodian or escort reasonably believes that the patient may be found on those premises; and

(e) the custodian or escort (or any assistant) may take possession of and safeguard any medication, physical aid or other thing that the custodian or escort reasonably believes is or may be necessary to the patient's health, safety or welfare; and

(f) the custodian or escort (or any assistant) may take possession of and safeguard any medication, prescription or other thing that the custodian or escort reasonably believes is or may be relevant to the patient's examination, assessment, treatment or care; and

(g) the custodian or escort may, as circumstances require, transfer physical control of the patient to another custodian or escort or to another police

officer, MHO or authorised person (who then has, and may exercise, any powers of the transferring custodian or escort under this clause); and

(h) the custodian or escort is not required to be in close physical proximity to the patient during any examination or assessment.

2. Search power of custodians and escorts

(1) To take a patient into protective custody or under escort –

(a) the custodian or escort may conduct a frisk search or ordinary search of the patient if the custodian or escort reasonably suspects that the patient may be carrying anything that could –

(i) be a danger to the patient or another person; or

(ii) assist the patient to escape; and

(b) the custodian or escort may seize anything found in the frisk search or ordinary search if he or she reasonably believes it is a thing of the kind referred to in paragraph (a)(i) and (ii); and

(c) the custodian or escort may retain anything seized in the frisk search or ordinary search and, as the circumstances may require or indicate –

(i) safeguard the thing for later return to the patient or transfer to a health professional or other person in connection with the patient's examination, assessment, treatment or care; or

(ii) dispose of thing as the custodian or escort thinks fit (after, if he or she adjudges it necessary or expedient to do so, obtaining any relevant advice or direction) including, if the thing is unlawful or dangerous and not required for evidentiary purposes, disposal by means of its destruction.

(2) Before conducting a frisk search or ordinary search pursuant to subclause (1), the custodian or escort is to inform the patient –

(a) why the search is to be conducted; and

(b) what the search will involve.

(3) A frisk search is, if practicable, to be conducted by a person of the same sex as the person being searched.

3. Proof of identity

(1) This clause applies if a person is purporting to exercise, discharge or perform a responsibility as a custodian or escort.

(2) Any affected party may ask the person to produce proof of identity.

(3) Subject to subclause (4), it is the person's duty to comply with the request.

(4) For the purposes of subclause (3), it is sufficient if the person –

(a) in the case of an MHO, produces his or her MHO identity card; or

(b) in the case of an authorised person, produces his or her identity card, if issued, or instrument of authorisation; or

(c) in the case of a police officer or ambulance officer who is not in uniform, produces his or her MHO identity card, if issued, or –

(i) in the case of a police officer, his or her warrant card; or

(ii) in the case of an ambulance officer, his or her ambulance officer identification card; or

(d) in the case of a police officer or ambulance officer who is in uniform, states that he or she is acting as authorised custodian or escort under this Act.

(5) A failure to comply with subclause (3) does not, of itself, invalidate the subsequent exercise,

discharge or performance of the relevant responsibility.

(6) The CFP or controlling authority of an SMHU may issue an authorised person with an identity card for use in connection with escort duties.

(7) In this clause –

affected party means any of the following:

(a) the patient;

(b) a representative or support person of the patient;

(c) the owner or occupier of any premises that the person purporting to act as custodian or escort is, in that capacity, seeking to enter;

(d) the controlling authority of an approved facility from which the person purporting to act as custodian or escort is, in that capacity, seeking to remove the patient;

(e) a Chief Psychiatrist.

4. Schedule does not limit certain powers

Nothing in this Schedule is to be taken to limit any powers of arrest, search and seizure that a person has under the laws of Tasmania.

PART 3 – POLICY

1. Custody and escort policy

As far as practicable –

(a) patients should not be taken into protective custody if they can be properly examined and assessed against the assessment criteria or treatment criteria without being taken into protective custody; and

(b) patients should not be taken into or held in protective custody or taken or held under escort by force unless –

(i) persuasion or other non-forceful methods have been tried without success; or

(ii) the authorised custodian or escort reasonably believes that it would be futile or inappropriate to try such methods; and

(c) whenever practicable, the use of non-police custodians, escorts and assistants is to be preferred; and

(d) patients taken into protective custody or under escort should be transported with the least delay and discomfort as circumstances reasonably allow; and

(e) where a patient has been granted a leave of absence from an approved facility for

a private purpose under escort, the authorised escort is not to unreasonably interfere with the enjoyment of that leave.

SCHEDULE 3 – MEMBERSHIP OF TRIBUNAL

Section 167(6)

1. Term of office

(1) The President and the Deputy President each hold office for a term of 5 years.

(2) Each other member holds office for such term not exceeding 3 years as is specified in the member's instrument of appointment.

(3) If eligible, a member may be appointed for further terms.

(4) There is no limit on the number of times a person may be appointed as a member or be President or Deputy President.

2. Extension of term of office

(1) If a member's appointment expires while he or she is hearing any matter for the Tribunal, the member's term of appointment is taken to continue until the matter has been finally determined by the Tribunal.

(2) If –

(a) an eligible person, within the meaning of section 21A of the *Acts Interpretation Act 1931*, has been appointed to act as a member; and

(b) that acting appointment expires while the eligible person is engaged in hearing any matter for the Tribunal (whether the expiry is occasioned by the effluxion of time or the return to duty of the substantive member or another cause) –

the term of the acting appointment is taken to continue until the matter has been finally determined by the Tribunal.

3. Holding other office

The holder of an office who is required by the terms of his or her employment to devote the whole of his or her time to the duties of that office is not disqualified from –

(a) holding that office and also the office of a member; or

(b) accepting any remuneration payable to a member.

4. State Service Act

(1) A person may hold the office of member in conjunction with State Service employment.

(2) However, the *State Service Act 2000* does not apply to such a person in his or her capacity as a member.

5. Remuneration and conditions of appointment

(1) A member is entitled to be paid such remuneration and allowances as the Minister determines.

(2) However, a member who is a State Servant is not entitled to any such remuneration or allowance except with the approval of the Minister administering the *State Service Act 2000*.

(3) A member holds office on such conditions relating to matters not provided for by this Act as are specified in the instrument of appointment.

6. Filling of vacancies

If the office of a member becomes vacant, the Governor may appoint a person to the vacant office for the remainder of that member's term of office.

7. Vacation of office

(1) A member vacates office if he or she –

(a) dies in office; or

(b) resigns by notice given to the Governor; or

(c) loses, in the case of a member referred to in section 167(2)(a) or (b), the necessary professional standing; or

(d) ceases, in the case of the member referred to in section 167(2)(b), to be a psychiatrist; or

(e) is removed from office under subclause (2) or (3).

(2) The Governor may remove a member from office if the member –

(a) fails, without the Tribunal's permission, to make himself or herself available to attend to Tribunal matters for a period longer than 3 months; or

(b) becomes bankrupt, applies to take the benefit of any law for the relief of bankrupt or insolvent debtors, compounds with the member's creditors or makes an assignment of the member's remuneration or estate for their benefit; or

(c) is convicted, in Tasmania or elsewhere, of a crime or an offence punishable by imprisonment for a period exceeding 12 months; or

(d) is convicted of an offence against this Act.

(3) The Governor may remove a member from office if satisfied that the member is unable to perform the duties of the office adequately or competently.

8. Validity of proceedings, &c.

(1) An act or proceeding of the Tribunal (or of a person acting under the direction of the Tribunal) is not invalidated by reason only that at the time when the act or proceeding was done, taken or commenced there was a vacancy in the membership of the Tribunal.

(2) An act or proceeding of the Tribunal (or of a person acting under a direction of the Tribunal) is not invalidated by reason only of any defect or irregularity in –

(a) the appointment of any of its members; or

(b) the selection of a member of any of its divisions.

9. Deputy President

(1) The Deputy President may exercise and perform the President's powers and functions as a member of the Tribunal if –

(a) the President –

(i) delegates those powers and functions to the Deputy President; or

(ii) is absent from Tasmania; or

(iii) is prevented by illness or other incapacity from exercising and

performing those powers and functions; or

(b) no-one is holding the office of President.

(2) While the Deputy President is authorised to exercise and perform the President's powers and functions, a reference in this Act to the President is taken to be a reference to the Deputy President.

(3) While the Deputy President exercises and performs the President's powers and functions, the Deputy President is taken to be the President.

10. Delegation by President

The President may delegate to the Deputy President the exercise and performance of any of the President's powers and functions as a member of the Tribunal other than this power of delegation.

11. Expert assistance

(1) The Tribunal may authorise an Australian legal practitioner, medical practitioner or other person with special expertise to assist the Tribunal with any proceedings or other matter.

(2) The Tribunal is to bear the cost, if any.

SCHEDULE 4 – PROCEEDINGS OF TRIBUNAL

Section 167(7)

PART 1 – INTERPRETATION

1. Interpretation

In this Schedule –

party, to any proceedings, includes any person intervening in those proceedings;

patient, in relation to any proceedings, means the person to whom the proceedings relate;

proceedings means proceedings before the Tribunal;

Tribunal includes a division of the Tribunal.

PART 2 – GENERAL PROCEDURES

1. Sittings

The Tribunal is to sit at such times and places as the President determines.

2. Persons with standing

The following persons have standing to institute or intervene in proceedings:

(a) the patient;

(b) the patient's representatives;

(c) if the patient is or has been in an approved facility, the controlling authority of the approved facility;

(d) if the patient is not a forensic patient, the CCP;

(e) if the patient is a forensic patient, the CFP and, if the patient is also an involuntary patient, the CCP;

(f) the treating medical practitioner;

(g) by leave of the Tribunal, any other person who it considers to have a proper interest.

3. Persons who may intervene

The following persons have standing to intervene in proceedings:

(a) the Secretary;

(b) the Public Guardian and Deputy Public Guardian;

(c) if the proceedings concern a forensic patient who is a prisoner, the Director of Corrective Services;

(d) if the proceedings concern a forensic patient who is a detainee under the *Youth*

Justice Act 1997, the Secretary (Youth Justice).

4. Notice

(1) The Tribunal is to ensure that a party to any proceedings is given reasonable notice of each hearing held in the course of those proceedings.

(2) The Tribunal may notify such other persons of the hearing as it thinks fit in the circumstances.

5. General principles

In conducting any proceedings, the Tribunal must –

(a) proceed with as little formality and as much expedition as a proper consideration of the matter before it allows; and

(b) observe the rules of procedural fairness.

6. Evidence

(1) The Tribunal is not bound by the rules of evidence but may inform itself as it considers appropriate.

(2) Evidence before the Tribunal may be given –

(a) orally, in writing or partly orally and partly in writing; and

(b) on oath or affirmation or by statutory declaration.

(3) An oath or affirmation of a witness may be administered by any member of the Tribunal.

(4) Evidence given before the Tribunal is not admissible in any civil or criminal proceedings other than –

(a) proceedings for an offence against this Act; or

(b) proceedings for an offence committed at, or arising out of, a hearing before the Tribunal; or

(c) any other proceedings under this Act; or

(d) proceedings under the *Criminal Justice (Mental Impairment) Act 1999* or *Guardianship and Administration Act 1995*; or

(e) proceedings where another Act specifically allows or requires the admission of that evidence.

(5) A person who appears as a witness before the Tribunal has the same protection as a witness in proceedings before the Supreme Court.

(6) Despite sections 127A and 127B of the *Evidence Act 2001*, a medical practitioner or counsellor may disclose to the Tribunal information without

the consent of the patient to whom the information relates.

7. Representation

(1) A party to any proceedings is entitled to attend the hearings held in those proceedings.

(2) However, the Tribunal may exclude any person from any proceedings if it reasonably considers that the person's presence may be detrimental to his or her health, safety or welfare or that of another person who is present.

(3) A party to any proceedings may appear personally in the proceedings or be represented by an Australian legal practitioner, advocate or other person.

(4) The Tribunal is to make arrangements for the representation of a patient, if it considers that the patient is, or may be, personally incapable of making such arrangements and is not, or may not be, receiving useful assistance elsewhere in that regard.

(5) The Tribunal may, if it considers there is a need to do so, make arrangements for the representation of any other party to proceedings.

(6) For the purposes of subclauses (4) and (5), either or both of the following may occur:

(a) the Tribunal may adjourn the proceedings to make the necessary arrangements;

(b) the Registrar may make the necessary arrangements on the Tribunal's behalf.

8. Appearance

(1) When attending any proceedings in any capacity a patient is entitled to be dressed in ordinary (rather than institutional) clothing.

(2) The Tribunal is to ensure that, as far as practicable, this entitlement is respected.

9. Privacy

(1) The proceedings of the Tribunal are not open to the public unless it determines otherwise in a particular instance.

(2) If the Tribunal determines that any proceedings should be open to the public, any party to the proceedings may challenge that determination.

(3) After hearing such a challenge, the Tribunal may –

(a) close (or reclose) the proceedings to the public; or

(b) exclude from the proceedings any person who has no direct interest in them; or

(c) exclude from the proceedings any person who has not been authorised to be present.

(4) The Tribunal, by order, may exclude any disorderly, disruptive or obstructionist person from any proceedings.

(5) In this clause –

"proceedings" includes a part of proceedings.

10. Record of proceedings

The Tribunal is to make and keep a record of each of its proceedings.

11. Publication of proceedings

(1) The Tribunal may publish a record of any of its proceedings (including its determinations in those proceedings) particularly if it considers that the proceedings are of significance in terms of the operation of this Act, and, where it does so –

(a) is to suppress information that could reasonably be expected to disclose the identity of any patient or former patient; and

(b) may suppress any other information that could reasonably be expected to prejudicially identify any other person.

(2) The record so published is to be provided to every party to the proceedings.

PART 3 – FACILITATION OF PROCEEDINGS

1. Practice directions

(1) The President may, as he or she thinks fit –

(a) issue practice directions in relation to the practice and procedure of the Tribunal; and

(b) vary or revoke any such practice directions; and

(c) publish any such practice directions.

(2) The practice and procedure of the Tribunal is to be in accordance with the practice directions from time to time in force unless the provisions of any Act or the provisions of any statutory rules made under an Act provide otherwise.

PART 4 – POWERS

1. General powers

(1) The Tribunal may –

(a) by summons, require any person to appear before it to give evidence or to produce any document or other thing specified in the summons; and

(b) require any person appearing before it to produce any document; and

(c) require any person appearing before it to give evidence on oath or affirmation; and

(d) require any person appearing before it to answer questions; and

(e) proceed with and determine any proceedings notwithstanding the absence of a person who has been summoned to appear; and

(f) adjourn any proceedings from time to time and place to place.

(2) A summons must be served personally, by post or as directed by the Tribunal, and the Tribunal may in an appropriate case direct substituted service of the summons.

2. Medical assessment

(1) The Tribunal, by notice, may require the patient in any proceedings to have a medical examination by a specified medical practitioner if, having regard to the relevant proceedings, it is reasonable to make that requirement.

(2) The notice is to specify –

(a) the name of the medical practitioner who is to do the examination; and

(b) the time and place of the examination.

(3) The specified medical practitioner may be a member of the Tribunal.

(4) The time and place specified for the medical examination must be reasonable.

(5) The medical practitioner who does the medical examination must give the Tribunal and the patient a written report on its results.

(6) The Tribunal is to bear the cost of the medical examination.

(7) In this clause –

medical examination includes an examination of the physical, psychological and mental capacities of a patient.

3. Reports

The Tribunal may require a Chief Psychiatrist or the controlling authority of an approved facility to provide it with –

(a) a report on the patient in any proceedings; or

(b) copies of records about the treatment or care of the patient.

4. Visits

The Tribunal or any one or more of its members may visit and interview in private any patient by or in respect of whom an application has been made to the Tribunal.

5. Contempt of Tribunal

(1) A person is in contempt of the Tribunal if the person –

(a) at a hearing of the Tribunal or in going to or returning from a hearing of the Tribunal, insults a member of the Tribunal, the Registrar of the Tribunal, an MHT staff member or any person assisting the Tribunal; or

(b) deliberately interrupts a hearing of the Tribunal, or otherwise misbehaves at such a hearing; or

(c) creates or continues, or joins in creating or continuing, a disturbance in or near a place where a hearing of the Tribunal is being conducted; or

(d) obstructs or assaults a person attending a hearing of the Tribunal; or

(e) without lawful excuse, disobeys a lawful order or direction of the Tribunal made or given at a hearing of the Tribunal; or

(f) does anything at a hearing of the Tribunal or otherwise that would be contempt of court if the Tribunal were a judge acting judicially.

(2) The Tribunal may order that a person who under subclause (1) is in contempt of the Tribunal be excluded from the place where the hearing is being conducted.

(3) An MHT staff member, acting under the Tribunal's direction, may, if necessary using necessary and reasonable help and force, remove and exclude the person from the place.

PART 5 – VOTES AND DECISIONS

1. Voting

(1) Unless this Act expressly provides to the contrary, questions arising for determination by the Tribunal are to be determined by a majority of votes of the members present and voting.

(2) In the event of an equality of votes on a question arising for determination by the Tribunal, the question stands adjourned until the Tribunal is next convened.

2. Announcement of decision

(1) At the conclusion of any proceedings, the Tribunal may announce its determination.

(2) The announcement may be made by –

(a) the Tribunal sitting together; or

(b) the President sitting alone; or

(c) for a division of the Tribunal, the chair of the division.

(3) An announcement is to be in addition to, and not in substitution for, a written determination.

PART 6 – MISCELLANEOUS

1. Statements of reasons

(1) A party to any proceedings may, during the prescribed period, apply to the Tribunal for a written statement of its reasons for making any determination in or in respect of those proceedings.

(2) The Tribunal is to comply with the request within 21 clear days after receiving it.

(3) The statement of reasons is to be provided to every party to the proceedings.

(4) In this clause –

prescribed period means the 30-day period immediately after the day on which the relevant proceedings were finally determined.

SCHEDULE 5 – OFFICIAL VISITORS

Section 155(4)

1. Term of office

(1) The Principal Official Visitor holds office for such term, not exceeding 5 years, as is specified in his or her instrument of appointment.

(2) An Official Visitor holds office for such term, not exceeding 3 years, as is specified in his or her instrument of appointment.

(3) If eligible, a person may be appointed to the office of Principal Official Visitor or Official Visitor any number of times.

2. Holding other office

The holder of an office who is required by the terms of his or her employment to devote the whole of his or her time to the duties of that office is not disqualified from –

(a) holding that office and also the office of Principal Official Visitor or Official Visitor; or

(b) accepting any remuneration payable to the Principal Official Visitor or an Official Visitor.

3. State Service Act

The *State Service Act 2000* does not apply to the office of Principal Official Visitor or Official Visitor.

4. Remuneration and conditions of appointment

(1) The Principal Official Visitor is entitled to be paid such remuneration and allowances as are specified in his or her instrument of appointment.

(2) An Official Visitor is entitled to be paid such remuneration and allowances as the Minister may approve.

(3) However, a State servant is not entitled to be paid any remuneration or allowances under this clause except with the approval of the Minister administering the *State Service Act 2000*.

(4) The Principal Official Visitor and an Official Visitor hold office on such conditions relating to matters not provided for by this Act as are specified in their respective instruments of appointment.

5. Vacation of office of Principal Official Visitor, &c.

(1) The Principal Official Visitor vacates office if he or she –

(a) dies in office; or

(b) resigns by notice to the Governor; or

(c) is removed from office.

(2) The Governor, on the recommendation of the Minister, may remove a person from the office of Principal Official Visitor if the person –

(a) becomes bankrupt, applies to take the benefit of any law for the relief of bankrupt or insolvent debtors, compounds with creditors or makes an assignment of remuneration or estate for their benefit; or

(b) is convicted, in Tasmania or elsewhere, of a crime or an offence punishable by imprisonment for a period exceeding 12 months; or

(c) is convicted of an offence against this Act; or

(d) is given an approval of any kind under section 138 or 139.

(3) The Governor, on the recommendation of the Minister, may remove a person from the office of Principal Official Visitor if satisfied that the person –

(a) has engaged in behaviour that is incompatible with the standing of the office or compromises the person's ability to perform the functions of the office; or

(b) has acquired a financial or other interest of a kind that would render the person ineligible for appointment to the office; or

(c) has, as a result of any action or development, a conflict of interest with regard to the functions of the office; or

(d) is unable, for some other reason, to adequately or competently perform functions of the office.

(4) The Principal Official Visitor must not be removed from office otherwise than in accordance with this clause.

6. Vacation of office of Official Visitor, &c.

(1) An Official Visitor vacates office if he or she –

(a) dies in office; or

(b) resigns by notice to the Principal Official Visitor; or

(c) is removed from office.

(2) The Principal Official Visitor may remove a person from the office of Official Visitor if the person –

(a) becomes bankrupt, applies to take the benefit of any law for the relief of bankrupt or insolvent debtors, compounds with creditors or makes an

assignment of remuneration or estate for their benefit; or

(b) is convicted, in Tasmania or elsewhere, of a crime or an offence punishable by imprisonment for a period exceeding 12 months; or

(c) is convicted of an offence against this Act; or

(d) is given an approval of any kind under section 138 or 139.

(3) The Principal Official Visitor may remove a person from the office of Official Visitor if satisfied that the person –

(a) has engaged in behaviour that is incompatible with the standing of the office or compromises the person's ability to perform the functions of the office; or

(b) has acquired a financial or other interest of a kind that that would render the person ineligible for appointment to the office; or

(c) has, as a result of any action or development, a conflict of interest with regard to the functions of the office; or

(d) has blatantly or repeatedly contravened a code of conduct issued under section 156(3); or

(e) has blatantly or repeatedly acted contrary to directions issued by the Principal Official Visitor; or

(f) is unable, for some other reason, to adequately or competently perform functions of the office.

(4) An Official Visitor must not be removed from office otherwise than in accordance with this clause.

SCHEDULE 6 – LEGISLATION REPEALED

Section 228

Mental Health Act 1996 (No. 31 of 1996)

Mental Health Amendment Act 2005 (No. 32 of 2005)

SCHEDULE 7 – LEGISLATION RESCINDED

Section 229

Mental Health Regulations 2009 (No. 118 of 2009)