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LEGISLATIVE COUNCIL SELECT COMMITTEE

MENTAL HEALTH LEGISLATIVE MEASURES

Members of the Committee

Hon *Ivan Dean* MLC
Hon *Terry Martin* MLC
Hon *Ruth Forrest* MLC (Chair)
Hon *Jim Wilkinson* MLC

Secretary: Mrs Sue McLeod

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LIST OF ABBREVIATIONS

CCO	Continuing Care Order
CTO	Community Treatment Order
DEM	Department of Emergency Medicine
DPM	Department of Psychological Medicine
ED	Emergency Department
GAA	Guardianship and Administration Act
GAB	Guardianship and Administration Board
IO	Initial Order
MHA	Mental Health Act
MHCT	Mental Health Council of Tasmania
MHT	Mental Health Tribunal
MIST	Mobile Intensive Support Team
NGO	Non-Government Organisation
OV	Official Visitor
UN	United Nations

Executive Summary

Mental illness is an increasing health burden for many Tasmanians. Whilst issues related to the stigma of being diagnosed with a mental illness unfortunately persist in society, this is being addressed to some degree through organisations dedicated to protecting the wellbeing of people with psychiatric disability and/or addictions.

The National Survey of Mental Health and Wellbeing 2007 found that one in five (20%) Australian adults experience mental illness in any year and one in four of these people experience more than one mental disorder. Further to these disturbing statistics, the survey also found that almost half of the Australian population (45.5%) experience mental illness at some point in their lifetime.[1]

Whilst the prevalence of mental illness is significant, only a small percentage of those who experience a mental illness require or are subject to the provisions of the current protective legislative framework existing in Tasmania. The four pieces of legislation that fall under this protective legislative framework are the *Mental Health Act 1996,* the *Guardian and Administration Act 1995,* the *Alcohol and Drug Dependency Act 1968* and the *Disability Services Act 1992.*

Mental health and the protective legislative framework that provides protection for those with serious illness requiring such care is a complex and challenging area. The Committee accept and acknowledge the differing views that have been expressed and the sensitivity and intricacy of this important area of health care. This is particularly important as the relevant legislation may render it lawful to deprive these people of their liberty and treat them under compulsion in some circumstances.

The balance between ensuring a person experiencing a serious mental illness receives appropriate and timely care and treatment in an involuntary manner**,** whilst also respecting and complying with human rights principles, is of utmost importance. The compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is deemed necessary and is provided without the cooperation or consent of the person, should only be as a last resort and subject to defined and prescriptive safeguards.

The development of a legal test of capacity is an important aspect of this reform and should be supported by clear practice guidelines. This test would enable a health care provider to appropriately determine whether a person is capable or incapable of consenting to health care based on a demonstrated understanding and appreciation of the information provided regarding both the health condition and the proposed treatment.

[1] Australian Bureau of Statistics (2007). *National Survey of Mental Health and Wellbeing: Summary of Results*. ABS Cat No. 4326.0. Canberra: ABS

The rights of the individual with capacity to refuse treatment are vitally important but at times would seem to be inconsistent with the best interests of that person. It would appear that the 'right to protection' also needs to be observed and ensured. It is necessary to ensure that the rights argument does not swing too far to the point where we see people 'dying with their rights on'[2].

The Committee considered the current legislative framework and investigated the most appropriate legislative schemes for the future needs of people with psychiatric disabilities and/or addictions. The review was timely and necessary as concerns had been raised by the medical profession, legal profession and families and carers of those experiencing serious mental illness/disability. These concerns related to issues regarding the current legislative framework and the capacity of this framework to meet world's best practice particularly pertaining to human rights principles and obligations under recently ratified human rights conventions.

Individuals experiencing mental illness**,** friends and family of those with mental illnesses and organisations actively involved in the care and treatment of people with psychiatric disabilities and/or addictions provided the Committee with valuable insights into the challenges and frustrations of living with and caring for**,** those with mental illness. Many raised concerns that the current legislative framework did not adequately protect the rights and wellbeing of those requiring protection, nor did it provide certainty and clarity for family members, carers and medical practitioners.

It is acknowledged that a review of the *Mental Health Act* 1996 (MHA) has been underway for several years prior to the commencement and during the course of this inquiry. The work of this Committee did not impede this review as the purpose of this inquiry was to consider the broader legislative framework surrounding the protective legislation related to those with psychiatric disabilities and/or addictions.

Advice provided by Government on the establishment of the Committee assured that a Mental Health Amendment Bill would be available for debate in Parliament earlier this year, however, the Minister stated during the Estimates Committee process that "we are not going to see the mental health bill now in this term of government."[3]

Mental health, particularly the area that is subject to the provisions of the protective legislative scheme, is a complex and at times confusing area. The Committee found the gathering of evidence and deliberations challenging. Much of the evidence was received with great sadness and much compassion for the witnesses and their families. The Committee was conscious of the frustrations and anguish experienced by those involved in the many and varied aspects of care and support of people experiencing mental illness.

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[2] McSherry, Professor Bernadette, Monash University, *Transcript of Meeting*, 5 May 2009, p. 24.
[3] Giddings, the Hon Lara, MP, Minister for Health, *Hansard*, 24 June 2009.

The Committee found that the current legislative framework does provide 'adequate' protection for people experiencing mental health illness, however in order to avoid and mitigate potential discrimination and provide 'optimal' protection for those people, changes to the existing framework are required.

The Committee recommends that all relevant legislation be reviewed with a view to developing a generic, capacity based legislative framework. It is acknowledged that there will be challenges in achieving this, including resourcing issues and the likelihood that those persons who fall under the forensic mental health area together with those who suffer particularly challenging conditions, may require separate legislation.

In considering the most appropriate legislative framework for the future and the requirement to comply with human rights principles, areas including appropriate treatments and therapies, informed consent and capacity, the role of Official Visitors, representation and advocacy, processes for review of orders and the use of advance directives in mental health care, were all considered and discussed.

Evidence was also received relating to incidental matters that are important and support the context of this inquiry. This evidence is discussed in more detail in the body of the report and covers issues such as resourcing of mental health services, access to, adequacy and appropriateness of care across all regions of Tasmania, services for children and adolescents, interstate recognition of orders and the role of police.

The Committee found that there are significant variations in the resourcing and services in various regions of the State and that there is a total lack of appropriate inpatient mental health services for children and adolescents. It is imperative that a facility be established to provide the appropriate level of service for this age group, particularly given the significant demand and high incidence of mental illness experienced by young people.[4]

Early intervention in a number of mental health disorders and prodromal symptoms or conditions has been shown to be beneficial in promoting positive short and long term mental health outcomes. Early intervention programs and interventions need to be adequately resourced and available. Dialectical behaviour therapy, a therapy shown to be effective in the management and treatment of people with borderline personality disorder, should be implemented in Tasmania.

Police time and resources are being adversely impacted through the requirements placed on police services to provide transport and supervision to and within the Departments of Emergency Medicine at the major hospitals in

[4] Sawyer M.G., Arney F.M., Baghurst P.A., Clark J.J., Graetz B.W., Kosky R.J., Nurcombe B., Patton G.C., Prior M.R., Raphael B., Rey J., Whaites L.C. and Zubrick S.R *Child and Adolescent Component of the National Survey of Mental Health and Well Being* accessed at http://www.health.gov.au/internet/main/publishing.nsf/Content/70DA14F816CC7A8FCA2572880010456 4/$File/young.pdf

the State. The prevalence of co-morbidity associated with mental health disorders and substance abuse is a contributing factor in this matter.

The Committee wishes to acknowledge the contribution to this important inquiry of the many members of the community who provided personal accounts of their individual circumstances related to mental illness. Their input provided Committee members with an insight into the challenges and frustrations associated with mental illness that cannot be obtained readily through other means. Their stories saddened, challenged and at times disturbed Committee members and have contributed significantly to the content of this report.

Parliament House, Hobart
6 October 2009

Ruth Forrest MLC
Chair

Conclusions

The Committee concludes that-

1. The current suite of protective legislation that is intended to protect the wellbeing and rights of those with mental illness requires comprehensive review.

2. Legislative powers authorising detention and involuntary treatment must be definitive and prescriptive with a threshold for involuntarily treating a person with capacity being of the highest order.

3. Legislative reform is required to address the rights and wellbeing of people with addictions.

4. It is imperative that an order to detain must also enable a capacity to treat.

5. Determination of an appropriate capacity test is a necessary component of any legislative reform.

6. There is a link between the use of drugs and alcohol, and mental health disorders.

7. There are areas within the current legislative framework that require review and amendment to ensure compliance with Human Rights Conventions.

8. An absolute principle or short term enunciation that people have an absolute right can be contrary to their best interests in terms of short and long term mental wellbeing.

9. The frequency and timing of reviews of orders should be reviewed.

10. All persons with a mental illness should have access to an advocate.

11. Persons appearing before a Mental Health Tribunal or Guardianship Board Hearing should be entitled to legal representation.

12. The role of the Official Visitor is an important part of the oversight of mental health services.

13. Advance directives could provide greater autonomy and choice for persons suffering acute mental illness and subject to the provisions of current and future protective legislation.

14. The current legislation does not provide adequate clarity and certainty to the medical profession to assist decision making.

15. It is important to provide continuity of care and carer for those with a mental illness.

16. The involvement and inclusion of family is important to the care and wellbeing of those with mental illnesses and should be facilitated when and where appropriate.

17. There is uncertainty regarding the operation of privacy laws related to access to relevant information concerning a person with a mental illness by carers and significant others, particularly in relation to the care of minors.

18. There is not an equal provision of mental health services across the state.

19. Different hospitals have varied and inconsistent support for persons with a mental illness presenting to the Department of Emergency Medicine.

20. Dialectical behaviour therapy provides an effective treatment for persons suffering from borderline personality disorders in other jurisdictions but is not available in Tasmania.

21. There is a lack of resources/services, particularly in-patient mental health services for children and adolescents. A visiting service of 10-12 days a year at Ashley is inadequate.

22. There is a need for interstate recognition of treatment orders.

23. There have been occasions where persons with serious mental health illness have received the most appropriate and effective care only after they have committed a crime and been treated as a forensic patient at the Wilfred Lopes Centre.

24. Early intervention in specific mental illness and conditions, such as Fragile X Syndrome, result in improved outcomes.

25. Evidence supports the benefit of and need for early intervention and treatment in serious mental health disorders.

26. Current training practices have resulted in police gaining a better understanding of people with a mental illness which has led to fewer complaints against police.

27. Police time and resources are consumed disproportionately when dealing with persons with mental illness requiring medical assessment.

Recommendations

The Committee recommends that-

1. Relevant Tasmanian legislation providing for the protection of people with mental health and other disabilities, be comprehensively reviewed and reformed to ensure that future legislation is developed to reflect a generic, capacity based framework.

2. The reform of the relevant legislation should-

a. Include a focus on treatment in the least restrictive alternative;
b. provide a single involuntary order that facilitates the capacity to treat either in the community or in hospital;
c. consider that there may need to be separate legislation to deal with forensic patients and other specific challenges;
d. be based and focused on compliance with human rights principles and representation;
e. ensure inclusion of all persons with a disability that impacts on their decision-making ability;
f. ensure greater clarity for the medical profession in the application of the legislation;
g. include those with serious dependencies;
h. consider the timing and frequency of the process for review of orders;
i. include the right to an advocate;
j. include the right to legal representation when attending a hearing;
k. reflect a social model rather than a medical model; and
l. maintain and review of the role of the Official Visitor.

3. The development of a capacity test is required to facilitate the legislative framework.

4. The overarching recommendations of the Bamford Report (see Appendix 1) may be broadly applied to the Tasmanian situation, in particular the following recommendations are relevant –

> *1. There should be a single, comprehensive legislative framework for the reform of Mental Health … This should be through the introduction of provisions for all persons who require substitute decision-making. A framework is proposed for interventions in all aspects of the needs of persons who require substitute decision-making, including mental health, physical health, welfare or financial needs.*
>
> *3. The principles underpinning new legislation should support the dignity of the person and have regard to-*

Autonomy: respecting the person's capacity to decide and act on his [or her] own and his [or her] right not to be subject to restraint by others.

Justice: applying the law fairly and equally.

Benefit: promoting the health, welfare and safety of the person, while having regard to the safety of others.

Least harm: acting in a way that minimises the likelihood of harm to the person.

4. These principles should apply in a non-discriminatory and balanced way to all healthcare decisions, as well as to welfare and financial needs.

5. Grounds for interfering with a person's autonomy should be based on his or her impaired decision-making capacity.

9. Persons who are subject to the Criminal Justice System should have access to assessment, treatment and care which is equivalent to that available to all other people.

10. Legislation must provide appropriate public and individual protection to the community against harm from persons whose decision-making capacity is impaired and who present a risk to others. On the other hand, legislation must not discriminate unjustifiably against persons who suffer from a mental health problem or learning disability.[5]

5. A broader definition of mental illness (see suggestions from other jurisdictions in Attachment 2) is required.

6. Adequate resourcing be provided to facilitate appropriate early intervention treatment and programs.

7. A dedicated mental health in-patient facility catering for the needs of children and adolescents be established in Tasmania.

8. The Government undertake a review of statewide mental health services, particularly in relation to access to and the availability and adequacy of–

a. Hospitals – DEMs
b. Step down facilities
c. Supported accommodation
d. Continuity of carer

[5] The Bamford Review of Mental Health and Learning Disability (Northern Ireland) *A Comprehensive Legislative Framework*, August 2007, pp. 84-88 accessed at http://www.rmhldni.gov.uk/legal-issue-comprehensive-framework.pdf.

9. Reciprocal arrangements between States for treatment orders be further investigated.

10. The provision of dialectical behaviour therapy for the treatment of persons suffering from borderline personality disorders be established and adequately funded and resourced in Tasmania.

11. The investigation and communication of the appropriate application of privacy laws with regard to the ability of parents/carers to receive information relevant and necessary to ensure appropriate care to those in their care, be undertaken by Government to ensure appropriate access to relevant information.

12. All Tasmanian and Australian Government departments ensure processes requiring interaction with clients with mental health or other disabilities such that they require the support of a guardian or power of attorney, recognise and facilitate these roles to ensure the client is not disadvantaged.

13. The introduction of advance directives be investigated for people with mental illness and/or addictions.

14. Police involvement in the care and supervision of persons with mental health disorders and those under the influence of drugs and/or alcohol be reviewed.

15. Appropriate police cells with access to a dedicated mental health nurse and police medical practitioner to assess persons considered under the influence of drugs and/or alcohol be investigated.

Appointment and Conduct of Inquiry

1.1 APPOINTMENT AND TERMS OF REFERENCE

On Tuesday, 26 August 2008 the Legislative Council resolved that a Select Committee be appointed with power to send for persons and papers, with leave to sit during any adjournment of the Council, and with leave to adjourn from place to place, to inquire into mental health legislative measures and report upon —

(1) The role and function of the protective legislative schemes with respect to promoting the rights and protecting the wellbeing of people with psychiatric disabilities and/or addictions;

(2) Whether Tasmania's legislation meets world's best practice in terms of providing –

(a) adequate protection for the rights and wellbeing of people with psychiatric disabilities and/or addictions and their families; and

(b) clarity and certainty for medical practitioners and support workers providing services to people with psychiatric disabilities and/or addictions and their families; and

(3) Any other matters incidental thereto.

The Committee comprised four Members of the Legislative Council – Mr Ivan Dean, Ms Ruth Forrest (Chair), Mr Terry Martin and Mr Jim Wilkinson.

1.2 THE REASON FOR ESTABLISHING THE COMMITTEE

The Committee was established to investigate the most appropriate legislative framework for the future needs of people with psychiatric disabilities and/or addictions. Such a review was necessary and timely as concerns had been raised regarding the current legislative framework and the capacity of this framework to meet world's best practice and obligations under recently ratified human rights conventions.

Some individuals and organisations actively involved in the care and treatment of people with psychiatric disabilities and/or addictions had raised concerns that the current framework may not adequately protect the rights and wellbeing of those that may require the protection that the legislation is intended to provide.

Concern had also been expressed by medical practitioners and family members involved in the care and treatment of people with psychiatric disabilities and/or addictions with regard to the lack of certainty and clarity related to the application of the current legislative framework and the recent changes in human rights conventions to which Australia is a signatory.

It is acknowledged that a review of the *Mental Health Act* 1996 has been underway for several years prior to the commencement of this inquiry and has continued during the course of this enquiry. It was anticipated that some of the areas of concern would be addressed through this review and that a draft Amendment Bill would have been available for consideration during the course of the inquiry. This has not occurred with the review of the current Act still in progress. Whilst proposed changes to the MHA suggest an advancement of the rights of people with mental illness, the review of the MHA does not alleviate the need for ongoing and comprehensive further reform.

The purpose of this Committee was to consider the broader legislative framework surrounding the protective legislation related to those with psychiatric disabilities and/or addictions and has not impeded or undermined the review process of the MHA.

In moving the establishment of the Committee, the Hon Ruth Forrest MLC stated in referring to the current legislation subject to review by the Committee-

> … it refers to those people with mental health disorders who require protective legislation to ensure they receive appropriate, timely and effective care and/or treatment to enhance their wellbeing. In doing so, this legislation may render it lawful to deprive these people of their liberty and to provide treatment under compulsion in some circumstances.[6]

Ms Forrest stressed the point that "… it is not a lighthearted approach we need to be taking here, this is a serious piece of legislation that does have the capacity to deprive people of their liberty and we need to be very careful about how that is used".[7]

Members of the Legislative Council were encouraged to support the establishment of the Select Committee, as-

> This will be an opportunity for us, as the elected representatives of Tasmanians, to demonstrate how we can support mental wellness in our community as well as to provide a protective and empowering legislative system for those who experience psychiatric disabilities.[8]

1.3 PROCEEDINGS

The Committee called for evidence in advertisements placed in the three daily newspapers. In addition invitations were sent to key stakeholder groups and individuals.

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[6] Forrest, Hon Ruth MLC, *Hansard*, 26 August 2008.
[7] *Ibid.*
[8] *Ibid.*

Twenty-seven written submissions were received and verbal evidence was given by forty witnesses in Tasmania and six people interstate. Some Members of the Committee also visited “Tyenna”, supported accommodation for people with mental illness.

The Committee met on fifteen occasions. The Minutes of such meetings are set out in Attachment 4.

The witnesses are listed in Attachment 1. Documents received into evidence are listed in Attachment 3.

Chapter 1 – INTRODUCTION

> They won't take him. He gets grumpy, he is big and a bit scary. He is a big, muscly bloke and when he is ill, when he is anxious and panicky, people find it scary and they just don't like it. …He rings the police and they come and get him and help him and he goes off to the hospital and they might or might not admit him depending on the circumstances. If I go with him they will probably admit him because I can advocate on his behalf. If he goes by himself they will turn him away.[9]

The provision of protective legislative schemes to protect the rights and wellbeing of people with psychiatric disabilities and/or addictions is a difficult and complex task. One piece of legislation cannot address all the problems, as the problems are not only legislative, but also include cultural and ethical aspects. The 'right to protection' of individuals must be foremost in the consideration of any change.

In accordance with the Terms of Reference approved by the Legislative Council, the primary focus of this Committee's inquiry has been the adequacy or otherwise of protective legislative schemes that operate within Tasmania for people with psychiatric disabilities and/or addictions.

This report encompasses evidence presented to the Committee in the areas of human rights obligations, the appropriateness of a generic capacity-based legislative framework as opposed to the current legislative approach, including the existence of a specific MHA, and issues surrounding clarity and certainty for families and practitioners.

As could be expected from any examination of such mental health legislative measures, evidence provided to the Committee came from a large number of individuals and organisations and covered a wide range of issues, not all strictly within the scope of the primary focus of the inquiry.

Nevertheless, all the evidence received, both in written and verbal forms, has given the Committee important and valuable insights into the operation of the State's protective legislative schemes.

According to the written submission provided by the Mental Health Council of Tasmania-

> Forty five percent of Australians have experienced a mental illness at some stage of their life, with 20 percent of the Australian population having experienced a mental illness in the last twelve months. Importantly, only 35 percent of these people accessed some form of mental health services, including a general practitioner.[10]

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[9] Private Witness 1, *Transcript of Evidence*, pp. 9-10.
[10] Mental Health Council of Tasmania, *Written Submission*, LCSC/MHL/13, p. 3.

As the Tasmanian Government submission to the Committee noted, "mental illness affects everybody in the community either directly or indirectly."[11]

The submission goes on to point out that-

> Today, approximately 3% of Tasmania's population are experiencing a mental illness and over the next year another 17% will experience a mental health problem. Over the course of a lifetime, one in five people will experience mental health difficulties.[12]

The figures above do display some difference in actual percentages, however, the evidence would suggest that the extent of the population who experience mental illness is significant, with a high number of people directly experiencing mental illness during their lifetime. There are also many others, including family and friends of those who experience mental illness, directly impacted through the effect on those individuals.

Whilst these figures represent a significant proportion of the population, it should be noted that the majority of those experiencing mental illness voluntarily give their informed consent to treatment and therefore are not subject to the provisions of the MHA. Their care and treatment generally occurs outside any specific legislative framework. Only a relatively small number of people with a psychiatric disability or addiction cannot or will not provide informed consent to undergo treatment. It is only this latter section of the population who are subject to the protective legislative schemes which are the focus of this inquiry.

However, it was pointed out by a number of those presenting evidence to the Committee that all those with a psychiatric disorder or addiction (i.e. approximately 20 per cent of Tasmanians over a lifetime) are unfairly and unreasonably stigmatised by the existence of legislation specifically relating to mental health. Although this specific matter is technically outside the Committee's Terms of Reference, it is still of relevance when considering the broader question of whether there is a need, in terms of world's best practice, for the current *Mental Health Act 1996* to be maintained. That question is discussed later in this report as part of the consideration of whether Tasmania's protective legislative schemes meet the standards of world's best practice.

In Chapter 2, the report outlines the role and function of the existing protective legislative schemes, in accordance with Term of Reference No. 1, with particular attention to how they promote the rights and protect the wellbeing of those with psychiatric disorders and/ or addictions.

This chapter also considers the operation of existing legislation and the associated problems with definitions and the key concepts.

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[11] Tasmanian Government, *Written Submission*, LCSC/MHL/25, p. 3.
[12] *Ibid.*

Chapter 3 summarises the evidence presented to it in terms of whether the Tasmanian legislation meets world's best practice in terms of human rights, official visitors and the processes for the review of orders for detention and treatment.

Chapter 4 outlines the evidence presented in terms of whether the Tasmanian legislation provides adequate protection for the rights and wellbeing of people with psychiatric disorders and/or addictions and their families, as well as providing clarity and certainty for medical practitioners and support workers.

Chapter 5 refers to several matters incidental to the Terms of Reference and worthy of special note.

Chapter 6 provides suggestions to guide future legislative reform and the recommendations are listed at the front of this report.

One of the overarching matters of relevance in the conduct of this inquiry has been the question of definitions used in legislation. This is particularly in relation to the determination of mental illness, informed consent and the determination of capacity to give informed consent. These and other definitions, together with matters related to such definitions and their application, were regularly mentioned in evidence to the Committee.

The Committee felt it was helpful to an understanding of the evidence that several of the existing key definitions be set out at the beginning of the following Chapter.

Chapter 2 – LEGISLATION

KEY DEFINITIONS

"forensic patient" means a person who is admitted to a secure mental health unit in accordance with section 72A (MHA) and who has not been discharged from that secure mental health unit

"guardian" means a person named as a guardian in a guardianship order or as an enduring guardian in an instrument of appointment as such.

"informed consent" means –

(1) A person is taken to have given informed consent to proposed medical treatment if, and only if, the following requirements are satisfied -

(a) the person is, in the opinion of the medical practitioner who is responsible for administering the proposed treatment, mentally capable of understanding the general nature and effect of the proposed treatment;
(b) the person, after being given the information required under subsection (2), freely and voluntarily consents to the proposed treatment;
(c) the person has not withdrawn the consent.

(2) The medical practitioner who is responsible for the administration of medical treatment to a person must give the person whose consent to medical treatment is sought –

(a) a clear explanation of the proposed treatment; and
(b) a description, without concealment or distortion, of the benefits and disadvantages of the treatment, including a statement of the risk of adverse consequences; and
(c) a description of alternative forms of treatment that may be available and their benefits and disadvantages; and
(d) clear answers to questions asked by the person; and
(e) a reasonable opportunity to obtain independent medical or other advice.

"involuntary patient" means –

(a) a person in respect of whom an order is in force under this Act; or
(b) a person who is admitted to an approved hospital on the authority of an authorisation for temporary admission

"mental illness" means –

(1) A mental illness is a mental condition resulting in –

(a) serious distortion of perception or thought; or
(b) serious impairment or disturbance of the capacity for rational thought; or
(c) serious mood disorder; or
(d) involuntary behaviour or serious impairment of the capacity to control behaviour.

(2) A diagnosis of mental illness may not be based solely on –

(a) antisocial behaviour; or
(b) intellectual or behavioural nonconformity; or
(c) intellectual disability; or
(d) intoxication by reason of alcohol or a drug.

"official visitor" means a person appointed as an official visitor under section 74P – which states:

(1) The Governor may, on the recommendation of the Minister, appoint official visitors.

(2) An appointment is to be made –

(a) for a region specified in the instrument of appointment; or
(b) for a nominated approved hospital; or
(c) for a nominated secure mental health unit –

and for each such region, hospital or secure mental health unit one of the official visitors is to be appointed as coordinator to arrange the visits and the exercise of the other functions of the official visitors.

(3) A person is not eligible for appointment if the person –

(a) holds an office in the Department; or
(b) has an interest in a contract with the Crown, an approved hospital or a secure mental health unit; or
(c) has a financial interest in an approved hospital or a secure mental health unit.

CURRENT TASMANIAN LEGISLATION

The Committee believes that a generic capacity-based legislative framework is more appropriate for the future protection of those with a psychiatric disability and/or addiction. In the written submission from Ms Anita Smith, President of the Guardianship and Administration Board and Ms Debra Rigby, President of the Mental Health Tribunal, they stated that-

> Tasmania's legislation may provide 'adequate' protection, but it does not provide 'optimal' protection and currently requires some significant improvements to eliminate discrimination.[13]

As stated in the previous chapter, it is acknowledged that a review of the Mental Health Act is currently underway and that the work of this Committee has not impeded that review in any way.

The Tasmanian Government provided a written submission to the Committee which included an overview of the relevant legislation**.** The overview has been inserted below to assist in understanding the role and function of each particular Act-

"Mental Health Act 1996

Each Australian State and Territory has specific legislation regulating the care, treatment and detention of persons with a mental illness.

In Tasmania, the Mental Health Act legislates for the care and treatment of persons with a mental illness. It provides specific legislative authority for a person with a mental illness to be:

- *involuntarily detained if, because of the person's mental illness, there is a significant risk of harm to the person or others and the person's detention is necessary in order to protect the person or others (Continuing Care Order)[14]; and/or*
- *placed on an order providing for the person's treatment in the community (Community Treatment Order) if, because of the person's mental illness, there is a significant risk of harm to the person or others unless the mental illness is treated, and the order is necessary to ensure that the illness is properly treated[15].*

The Mental Health Act contains provisions for matters including:

- *the concept of 'person responsible' and 'informed consent'[16];*
- *the approval of hospitals, assessment centres and secure facilities and the appointment of medical practitioners and authorised officers[17];*
- *the office of the Chief Forensic Psychiatrist[18];*
- *the voluntary admission of persons with a mental illness to an approved hospital[19];*
- *taking a person into protective custody[20];*

[13] Guardianship and Administration Board and Mental Health Tribunal (hereinafter GABMHT), *Written Submission*, LCSC/MHL/8, p. 15.
[14] By way of an Initial (section 24) or Continuing Care (section 28) Order made under the *Mental Health Act*.
[15] By way of a Community Treatment Order made pursuant to section 40 of the *Mental Health Act*.
[16] Sections 5 and 5AA, respectively.
[17] Sections 9 – 13.
[18] Sections 11A – 11C.
[19] Sections 17 - 23.
[20] Sections 15 – 16.

- *the involuntary detention of persons with a mental illness in an approved hospital by way of:*
  - *Initial Orders[21];*
  - *Continuing Care Orders[22];*
- *the involuntary medical treatment of persons in the community by way of Community Treatment Orders[23];*
- *'non-medical treatments' (interventions) including:*
  - *Seclusion and restraint[24];*
  - *Patient leaves of absence, transfer between facilities and humanitarian transfers[25];*
- *involuntary patient's rights to information[26];*
- *the establishment, functions, proceedings, members and staff of the Mental Health Tribunal (the Tribunal)[27];*
- *the appointment, functions, visits and reports of Official Visitors[28]; and*
- *the apprehension and return of absconding patients[29].*

Protective Custody

The protective custody provisions of the Mental Health Act are utilised in order to take a person to an assessment centre so that the person can be examined and diagnosed by a medical practitioner to determine whether the person should be placed on an Initial Order.

A police officer or authorised officer may take a person into protective custody if the officer considers, on reasonable grounds, that:

- *the person has a mental illness; and*
- *there is in consequence, a significant risk of harm to the person or others.*

For the purposes of taking a person into protective custody, an authorised officer may enter premises where the person is reasonably considered to be, may be accompanied by a police officer or assistants, and may use reasonable force.

Initial Orders

The purpose of an Initial Order is to provide a compulsive mechanism to facilitate a person's examination and assessment to determine whether the criteria for detention as an involuntary patient are met.

[21] Sections 24 – 27.
[22] Sections 28 – 30.
[23] Sections 40 – 44C.
[24] Sections 34 – 36.
[25] Sections 37 – 39.
[26] Sections 45 – 47.
[27] Sections 48 - 72 and Schedule 1.
[28] Sections 74P – 81.
[29] Sections 82 – 83G.

A person may only be placed on an Initial Order if the following criteria for detention as an involuntary patient are met:

- *the person appears to have a mental illness; and*
- *there is, in consequence, a significant risk of harm to the person or others; and*
- *the detention of the person as an involuntary patient is necessary to protect the person or others; and*
- *the approved hospital to which admission is proposed is properly equipped and staffed for the care or treatment of the person.*

A person may be placed on an Initial Order by a medical practitioner following application by an authorised officer or person responsible.

An Initial Order allows for a person's involuntary admission to an approved hospital for 24 hours. An Initial Order may be extended for up to 72 hours if the Initial Order is confirmed by an approved medical practitioner (generally, a psychiatrist). An Initial Order is also authority for the person to be taken into protective custody for the purposes of taking the person to an approved hospital.

Continuing Care Orders

A person who is on an Initial Order, Community Treatment Order (see below) or who is subject to an authorisation for temporary admission may be placed on a Continuing Care Order by two medical practitioners, one of whom must be an approved medical practitioner, if the person meets the criteria for detention as an involuntary patient (noted above).

A Continuing Care Order allows for the person's involuntary detention in an approved hospital for up to six months. Continuing Care Orders may be renewed for subsequent periods of six months, by two approved medical practitioners.

Community Treatment Orders

Community Treatment Orders are authority for the provision of involuntary treatment to a person in the community. A person may be placed on a Community Treatment Order by two approved medical practitioners if the person:

- *has a mental illness; and*
- *there is, in consequence, a significant risk of harm to the person or others unless the mental illness is treated; and*
- *the order is necessary to ensure that the illness is properly treated; and*
- *facilities or services are available for the care and treatment of the person.*

Community Treatment Orders last for up to 12 months and may be renewed for subsequent periods of 12 months by two approved medical practitioners.

An approved medical practitioner may authorise the temporary admission of a person who is on a Community Treatment Order to an approved hospital if:

- *the person fails to comply with the order; and*
- *all reasonable steps have been taken to obtain the person's cooperation in complying with the order; and*
- *the person's health has deteriorated, or there is a significant risk of this occurring, because of the person's failure to comply with the order.*

An authorisation for temporary admission is authority for the person to be taken into protective custody and detained in the approved hospital for up to 14 days. The Community Treatment Order is suspended for the time that the person is detained under an authorisation for temporary admission.
Following an authorisation for temporary admission, the person may either be returned to the community at which point the Community Treatment Order would continue, or placed on a Continuing Care Order requiring the person's continued detention in an approved hospital.

The Mental Health Tribunal

Section 48 of the Mental Health Act establishes the Tribunal.

The Tribunal is an administrative review tribunal that conducts hearings to determine whether it is necessary for a person who has been placed on an involuntary order under the Mental Health Act to continue to be treated as an involuntary patient. These hearings are conducted in relation to:

- *orders to detain a person as an involuntary patient in an approved hospital under Continuing Care Orders;*
- *the making of a Community Treatment Order; and*
- *an authorisation to return a person subject to a Community Treatment Order to hospital against their will (authorisation for temporary admission).*

The functions of the Tribunal reflect the human rights focus of the Mental Health Act, and the serious view the law takes of depriving a person of their freedom, whether this is freedom to leave the hospital or the freedom to live in the community without one's lifestyle being restricted by the decisions of health care providers.

The Tribunal must review all Continuing Care Orders and Community Treatment Orders within 28 days of their making or renewal.

Secure Mental Health Unit

Part 10A (sections 72A – 74O) and Schedule 1A were introduced to the Mental Health Act in 2006 to accommodate the establishment of the secure mental health unit and to facilitate its operation.

Part 10A relates exclusively to the secure mental health unit, the admission, treatment and detention of forensic mental health patients, and the establishment, functions, membership and proceedings of the Forensic Mental Health Tribunal and the Forensic Tribunal Member Register.

Forensic patients are, in the main, people who have a mental illness and who have been or are the subject of legal proceedings. A forensic patient may still be before the courts, may be in the process of being assessed for fitness to stand trial, may have been found not guilty of an offence or crime by reason of insanity, or may be a sentenced prisoner with a mental illness.

In general, forensic patients can be admitted to the secure mental health unit:

- *from prison if the person is held in prison as a sentenced prisoner or remanded in prison;*
- *if the person is under 18 years of age and has been sentenced to a period of detention at Ashley Youth Detention Centre or remanded to Ashley Youth Detention Centre;*
- *by Court order if the Court detains them in a secure mental health unit rather than prison while they are awaiting trial, during their trial or pending a sentencing decision (including where a court orders a person to be detained in a secure mental health unit for assessment);*
- *if they have been placed on a restriction order; or*
- *if they have breached or are likely to breach the conditions of their supervision order.*

Prior to the establishment of the secure mental health unit, forensic patients were held within Risdon Prison and administered along custodial lines.

The establishment of the secure mental health unit in 2006 enabled a health-based model of forensic mental health management focussing on the rights of patients to be treated for their illness while being detained outside a prison environment. The inclusion of the provisions within the Mental Health Act emphasises a treatment, rather than an offence-based, focus and is facilitative of addressing the patient's condition and reducing risk to the community.

Forensic Tribunal

Section 73T of the Mental Health Act establishes the Forensic Tribunal which undertakes a number of functions in relation to people admitted to a secure mental health unit. This includes:

- *hearing and determining applications for leave from the secure mental health unit;*
- *undertaking reviews of orders made in relation to forensic patients;*
- *hearing and determining applications for the authorisation of medical treatment for forensic patients; and*
- *receiving reports relating to medical treatment and other issues relating to forensic patients.*

Consent to treatment

The Mental Health Act was drafted in conjunction with the Guardianship and Administration Act, to jointly replace the Mental Health Act 1963 (the 1963 Act). The Mental Health Act regulates a person's placement on a Continuing Care or Community Treatment Order, while the Guardianship and Administration Act establishes a substitute decision making framework for persons who are unable to provide informed consent to treatment (because of a disability):

- *by a person responsible if the treatment is in the best interests of that person (including a guardian appointed pursuant to the Guardianship and Administration Act)[30];*
- *consent deemed by law (whereby emergency medical or dental treatment, minor treatment or treatment in the person's best interest where the person does not object to the treatment may be provided without the consent of the person or substitute consent); or*
- *by the Guardianship and Administration Board (the Board), where there is no person responsible, the patient is objecting to the treatment and where the treatment is in the best interests of that person. Consent is also given by the Board for certain "special treatments" prescribed by the Guardianship and Administration Regulations 2007 or where there is no person responsible and consent is required by virtue of the Guardianship and Administration Regulations[31].*

Although rarely used in practice, section 32 of the Mental Health Act formally extends the substitute decision making framework established by the Guardianship and Administration Act for persons with a mental illness, by enabling the Board to authorise treatment for a person regardless of their capacity, if satisfied that:

- *the person has a mental illness that is amenable to medical treatment; and*

[30] Section 43 of the Guardianship and Administration Act 1995.
[31] Section 45 of the Guardianship and Administration Act 1995.

- *a medical practitioner has recommended medical treatment for the illness but the person has refused or failed, or is likely to refuse or fail, to undergo the treatment; and*
- *the person should be given the treatment in his or her own interests or for the protection of others.*

…

Further information on the Guardianship and Administration Act is set out below in this submission.

Alcohol and Drug Dependency Act 1968

The Alcohol and Drug Dependency Act provides for the treatment and control of persons suffering from alcohol or drug dependency[32]. It enables a person suffering from alcohol or drug dependency to be involuntarily detained in a treatment centre for up to six months for the purpose of treatment, if this is necessary in the interests of the person's health or safety, or for the protection of other persons[33].

A welfare officer or relative may seek a person's involuntary admission to a treatment centre[34]. An application must be accompanied by a medical recommendation[35]. An application has effect for up to 14 days after it is made, for a person to be taken to and admitted to a treatment centre. Once admitted, the person may be detained lawfully under the Alcohol and Drug Dependency Act for up to 14 days.

The person's detention may be extended to a total of 6 months on the basis of a certificate issued by an appropriate medical officer (either the Superintendent of the treatment centre or a medical practitioner directed by the Superintendent to examine the patient). The period of detention may be extended by further six month periods if considered to be necessary in the interests of the patient's health or safety or the protection of other persons[36].

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[32] Section 3 of the *Alcohol and Drug Dependency Act* provides that "…a person shall be regarded as suffering from alcohol dependency if he consumes alcohol to excess and –
is thereby dangerous at times to himself or to others or incapable at times of managing himself or his affairs; or
shows prodromal signs of becoming so dangerous or so incapable".
Section 4 of that Act goes onto provide that "...a person shall be regarded as suffering from drug dependency if he takes drugs to the extent that-
he is thereby dangerous at times to himself or to others or incapable at times of managing himself or his affairs; or
he shows prodromal signs of becoming so dangerous or so incapable..."
where dependency "means a condition of a person arising from the taking of a substance that is manifested by:
an interference with his bodily or mental health; or
an interference with his capacity to engage in ordinary relations with other persons or to earn his own livelihood or to undertake any duties or perform any functions that he might reasonably expect to undertake or perform..."

[33] Section 24 of the Alcohol and Drug Dependency Act.

[34] Section 23 of the Alcohol and Drug Dependency Act and Regulation 7 of the Alcohol and Drug Dependency Regulation 1999.

[35] Section 24 of the Alcohol and Drug Dependency Act and Regulation 7 of the Alcohol and Drug Dependency Regulation 1999.

[36] Section 26 of the Alcohol and Drug Dependency Act.

A person may also seek their own admission to a treatment centre[37].

The Alcohol and Drug Dependency Tribunal is established by the Alcohol and Drug Dependency Act[38]. The Tribunal[39] consists of five members, three of whom are legally qualified medical practitioners and two of whom are persons with other suitable qualifications or experience[40]. The Tribunal's function is to hear and determine applications made to it by a patient or his/her relatives following detention in a treatment centre[41]. The Tribunal can, following a hearing of the application made by the detained person, either confirm the detention or recommend the patient's discharge from detention. The Alcohol and Drug Dependency Tribunal has no formal decision-making role in relation to detaining a patient in the treatment centre at the point that the decision is made.

Part III of the Alcohol and Drug Dependency Act refers to the prescribing and authorisation to supply certain drugs by medical practitioners for administration to an individual in circumstances where drug dependency is or may be an issue. Pursuant to the Alcohol and Drug Dependency Act, a medical practitioner is required to give notice to the Secretary that a person is suffering from drug dependency where it appears to a medical practitioner that a person consulting, or attended or treated by, him is suffering from drug dependency[42].

A person suffering an alcohol or drug dependency who lacks the capacity to make decisions for him or herself would not generally fall under the provisions of the Guardianship and Administration Act for the purposes of substitute decision making around treatment for the condition, on the basis that the person's condition (in the absence of a diagnosed disability and resultant incapacity) would not constitute a disability within the meaning of that Act[43].

Disability Services Act 1992

The Disability Services Act provides the legislative basis for the funding and provision of services for people with a disability in Tasmania in accordance with prescribed standards, principles and objectives, and for other related purposes.

Under the Disability Services Act "disability" means a disability

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[37] Section 23 of the Alcohol and Drug Dependency Act.
[38] Sections 7 – 11 of the Alcohol and Drug Dependency Act.
[39] Sections 7 – 11 of the Alcohol and Drug Dependency Act.
[40] Section 8 of the Alcohol and Drug Dependency Act.
[41] Section 9 of the Alcohol and Drug Dependency Act.
[42] Section 18 of the Alcohol and Drug Dependency Act.
[43] "Disability" is defined in the *Guardianship and Administration Act* as any restriction or lack (resulting from any absence, loss or abnormality of mental, psychological, physiological or anatomical structure or function) of ability to perform an activity in a normal manner. See http://www.guardianship.tas.gov.au/__data/assets/pdf_file/0008/88514/XT__Admin__6.3.06.pdf for a decision from the Guardianship and Administration Board around alcohol dependence not constituting a disability.

(a) which is attributable to an intellectual, psychiatric, sensory or physical impairment or a combination of those impairments; and
(b) which is permanent or likely to be permanent; and
(c) which results in –
(i) a substantially reduced capacity of a person for communication, learning or mobility; and
(ii) the need for continuing support services; and
(d) which may or may not be of a chronic episodic nature;

The Disability Services Act provides a set of objectives, principles and standards that recognise and promote the rights of people with a disability, and establishes a requirement for all funded disability service providers to be periodically reviewed against the standards.

The Disability Services Act also establishes the Disability Services Ethics Committee. The functions of the Ethics Committee include:

a) to monitor programs and services relating to people with a disability to ensure that they are designed and administered so as to be as free as possible from adversive, restrictive and intrusive treatment practices;
b) to report, or give recommendations, to the Minister in respect of such programs and services generally or in relation to specific treatment practices; and
c) such other functions as the Minister may determine.

The Disability Services Act does not make any provisions in relation to treatment or protective measures.

The Disability Services Act was developed following decades of increasing international recognition of the rights of persons with a disability, evidenced by way of the:

- *Declaration on the rights of Mentally Retarded Persons (1971);*
- *Declaration of Rights of Disabled Persons (1974);*
- *International Year of Disabled Persons (1981);*
- *Decade of Disabled Persons (1983-1992); and*
- *United Nations Standard Rules on the Equalisation of Opportunities for Persons with Disabilities (1993).*

Other key influences include the emergence of strong social and political disability movements in the United Kingdom and United States in the mid 1970's, the emergence of the independent living movement, parent-led advocacy groups and the need to develop appropriate services for returned veterans with acquired injuries following the Vietnam war.

Between 1983 and 1984 the Commonwealth Government conducted a review of programs for people with a disability (the Handicapped Programs Review). The Commonwealth Disability Services Act 1986 was developed in order to enable a more flexible range of services to be made available to people with a disability. The Commonwealth legislation simultaneously endorsed a

statement of Principles and Objectives setting out how services should be developed and delivered.

The Disability Services Act was modelled on the Commonwealth legislation. In conjunction with the development of State and Commonwealth anti-discrimination and equal opportunity legislation during the 1980's and 1990's, the Disability Services Act facilitated the development of a rights based, enabling framework for delivery of disability services and the development and funding of services specifically designed to meet the support needs of people with a disability.

From a practical perspective, the Disability Services Act is utilised primarily in order to develop eligibility guidelines for access to services funded or provided by Disability Services (on the basis of the definition of disability provided for in the Disability Services Act), to establish funding arrangements, to describe the standards, principles and objectives that apply to all funded service providers, and to provide for the periodic review of funded service providers against the standards.

Guardianship and Administration Act 1995

The Guardianship and Administration Act establishes the functions of the Board. Supplementary functions are established in Division 9 of the Wills Act 1992, Part 4 of the Powers of Attorney Act 2000 and section 32 of the Mental Health Act.

The Guardianship and Administration Act established 3 main schemes or areas of activity, namely that the Board can:

- *appoint guardians for adults with disabilities who do not have capacity to make important life decisions for themselves;*
- *appoint administrators to manage the financial estates of adults with disabilities who cannot manage their estates because of their disabilities; and*
- *make substitute decisions to consent to medical treatment on behalf of people with disabilities who lack the capacity to authorise such treatment themselves.*

Other statutory functions of the Board include giving advice and directions to guardians and administrators, registration of enduring guardianships, reviewing and, if necessary, revoking or altering an existing enduring power of attorney or enduring guardianship, creation of statutory wills and, in the case of unlawful detention of persons with a disability, ordering their removal to a safe place.

Because an adult's right to make financial and lifestyle decisions is a fundamental human right, such powers are only invoked where they represent the least restrictive alternative and where they will protect the best interests of the person. Consultation with the person with a disability is fundamentally important to the decisions of the Board.

The Board operates as an independent statutory tribunal. Hearings are conducted as much as possible in an informal inquiring style primarily to facilitate the meaningful inclusion of people with disabilities into the process of taking evidence. The informal style encourages participation wherever possible. The inquiry functions ensure that all of the necessary factual materials relevant to an application are compiled and presented to the Board to be tested in the hearing.

As mentioned above, the Guardianship and Administration Act also establishes a substitute decision making framework by allowing consent to treatment to be provided by a person responsible in respect of an incapacitated person if the treatment is in the best interests of the incapacitated person. In practice, this is the most common way by which treatment is authorised for persons lacking capacity".[44]

OPERATION OF EXISTING LEGISLATION

The manner in which these four pieces of legislation operate in conjunction with each other was an issue of concern to a number of those who gave evidence to the Committee.

According to the written submission from the Mental Health Council of Tasmania, the principal focus of both the *Alcohol and Drug Dependency Act* and the *Mental Health Act 1996* is the "perceived safety of the community", whilst the *Guardianship and Administration Act 1995* is centred on the "capacity of the person with mental illness."[45]

Other evidence described the *Mental Health Act 1996* as focusing on a test of "dangerousness" with regard to decisions about whether or not individuals should come under its ambit and orders should be made.[46]

This test is criticised by some involved in mental health services. Ms Smith and Ms Rigby contend that the test of dangerousness-

> Continue[s] the discrimination against persons with mental illness with capacity by not allowing them to refuse treatment outright, and

[44] Tasmanian Government, *op. cit.,* pp. 5-14.
[45] Mental Health Council of Tasmania, *op. cit.,* p. 3.
[46] Rigby, Ms Debra, *Transcript of Evidence*, 12 February 2009, p. 12. The Act refers to the protection of the person and others. See *Mental Health Act 1996*, Section 7:
"7. Principle of minimum interference with civil rights
In exercising powers conferred by this Act in relation to an involuntary patient, forensic patient or person subject to a supervision order or community treatment order, the following principles must be observed:
(a) restrictions on the liberty of the patient or person and interference with that patient's or person's rights, dignity and self-respect must be kept to the minimum consistent with the need to protect that patient or person and other persons and, in relation to a forensic patient, the good order and security of the secure mental health unit;
(b) effect must, if practicable, be given to that patient's or person's wishes so far as that is consistent with–
(i) that patient's or person's best interests; and
(ii) the need to protect that patient or person and other persons; and
(iii) in the case of a forensic patient, the good order and security of the secure mental health unit."

> continue the prejudice and stigma that attaches to civil patients as a result of forensic patients being dealt with in the same legislation.[47]

Ms Moya Cassidy from the Mental Health and Guardianship and Administration Representation Scheme, Legal Aid Commission of Tasmania was concerned that it is-

> …invoked by authorities as a basis for detaining mentally ill persons. However, like the concept of mental illness, the concept of dangerousness defies adequate, consistent or useful definition. This contemporary focus on dangerousness as a prime criterion for civil commitment arises from political as well as legal influence and provides no guarantee that the mentally ill will be provided with appropriate care and treatment.[48]

By contrast, the *Guardianship and Administration Act 1995* is said to focus upon the capacity of the individual and their best interests, as Advocacy Tasmania explained to the Committee-

> Guardianship is a protectionist mechanism for people who are incapable of making decisions because they are below the age set for the legal acceptance of an individual's right to autonomous decision-making or an adult who is incapable of making a decision due to a disability of the mind or an inability to communicate their decision because of their disability.[49]

According to the Tasmanian Government submission, the *Guardianship and Administration Act 1995* and the *Mental Health Act 1996* effectively "run in parallel."[50]

The Government submission explained the way the two Acts intersect by saying-

> Primarily, the use of each piece of legislation depends on the level or degree of the illness. Patients who are in an acute phase of their illness, but at other times are functionally well, are the primary source of matters under the *Mental Health Act*. Whereas, excluding medical consent, the primary source of matters for the [Guardianship and Administration] Board are persons with chronic longer term illness who may also have acute periods of illness.[51]

It was noted in some evidence that this parallel operation of both Acts can sometimes cause difficulties, especially for those who are mentally ill.[52]

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[47] GABMHT, *op. cit.,* p. 14.
[48] Mental Health and Guardianship & Administration Representation Scheme, Legal Aid Commission of Tasmania, *Written Submission*, LSCS/MHL/23, p. 12.
[49] Advocacy Tasmania Inc., *Written Submission*, LCSC/MHL/12, p. 12.
[50] Tasmanian Government, *op. cit*. p. 14.
[51] *Ibid.*
[52] Schneider, Dr Rosemary, *Written Submission*, LCSC/MHL/19, p. 5.

For example, evidence was presented that, in some instances, individuals have been required to appear before both the Guardianship and Administration Board and Mental Health Tribunal, which does not seem sensible nor does it appear to be reasonable.[53]

Tasmania has a separate Guardianship and Administration Board and Mental Health Tribunal, which hear cases in relation to the *Guardianship and Administration Act 1995* and the *Mental Health Act 1996* respectively. However, due to the way the provisions are structured, orders made under the *Mental Health Act 1996* are required to include treatment plans and interventions created under powers within the *Guardianship and Administration Act 1995*.[54]

Therefore people subject to orders under the Mental Health Act can be detained but not treated until the Guardianship and Administration Board issues an order to treat.

Ms Coral Muskett, statewide Director of Mental Health Services expressed concern regarding the need for two orders to facilitate treatment-

> One of the big downfalls, and I saw it time and time again when I was doing clinical practice and managing the acute unit at the Royal, was the lack of capacity to treat. I think it is very difficult for clinicians to detain people and not be able to treat them fairly early, especially when we know that all the evidence these days shows that the earlier you get in and intervene, especially when people have a major mental illness, the better their outcomes are.[55]

Dr Manilall Maharajh, Clinical Director, Launceston General Hospital agreed-

> … as a psychiatrist, the manner in which the act is currently formulated where a person can be incarcerated but not given duty of care, our first principle is to do no harm but to incarcerate someone and not treat them and see them go through the stress, I think is a huge harm. Therefore, it is that area of the act, particularly, that causes problems for me as a clinician in carrying out my duties as a doctor.[56]

Both tribunals have increasingly busy workloads with a rise in cases by approximately 20 per cent so far this year.[57]

Due to the requirements of the existing legislation and, therefore, the nature of the cases they are able or required to hear, there are situations, as mentioned

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[53] Schneider, *Written Submission, op. cit.,* p. 5.
[54] GABMHT, *op. cit.,* (Appendix 1)
[55] Muskett, Ms Coral, *Transcript of Evidence*, 23 March 2009, p. 30.
[56] Maharajh, Dr Manilall, *Transcript of Evidence*, 23 March 2009, p. 30.
[57] Robertson, Mr David, *Hansard*, Wednesday 24 June 2009 - Estimates Committee A (Giddings) - Part 2.

above, where individuals are required to appear before both the Guardianship and Administration Board and the Mental Health Tribunal.[58]

In a joint written submission, the presidents of the two bodies explained the need for review by both the Board and Tribunal in some situations, stating that-

> Mental health law assumes the relevance of safety of other persons by assessing the level of 'risk' a 'patient' poses to others. Guardianship applications however involve receipt of evidence about the person with a disability to the exclusion of the interests of other persons. The principles of finding the least restrictive alternative, observing the person's wishes and promoting the best interests of a person in guardianship are person-centred, allowing for eccentricities, foibles and habits even where these may offend the sensibilities of others. However, persons who become the subject of a guardianship order may by reason of their disabilities have dangerous characteristics to the same extent (or not) as a person with a mental illness. For instance a person disinhibited by the effects of a head injury with poor mood control or limited intellectual capacities can be equally dangerous and unpredictable as a person with a paranoid delusion.[59]

The Tasmanian Government submission highlighted that this group- "… are arguably the most acutely ill and the most in need of care and protection."[60] The same submission also acknowledged that this split in the legislation can be "…confusing."[61]

Professor Mark Oakley Browne, statewide Clinical Director of Mental Health Services suggested-

> The current act is a bit clunky, if you forgive the expression, in the sense that it does not fit well with current, modern clinical practice and processes. It places an emphasis on place of containment rather than treatment per se.[62]

Ms Coral Muskett had a somewhat differing view on the need to generic capacity based, and thus combined legislation. She stated-

> … there is quite a lot of talk about combining the guardianship legislation and the provisions of that act and the Mental Health Act. I think that there may be some fundamental problems with doing that if we are just looking at the generalised capacity to consent.[63]

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[58] GABMHT, *op. cit.,* p. 44: "…section 32 of the *Mental Health Act 1996* provides that decisions about treatment of a person with a mental illness will be made by the Guardianship and Administration Board even though the same Act establishes the Mental Health Tribunal."
[59] *Ibid*., pp. 19-20.
[60] Tasmanian Government, *op. cit.,* p. 17.
[61] *Ibid.*
[62] Oakley Browne, Professor Mark, *Transcript of Evidence*, 19 March 2009, p. 14.
[63] Muskett, *op. cit.*, p. 29.

Evidence provided to the Committee by witnesses from outside Tasmania also presented some concerns about the efficacy of the co-existence of the Guardianship and Administration Board and the Mental Health Tribunal.

Professor John Dawson, from the Faculty of Law at New Zealand's University of Otago, noted that-

> I think that the dual responsibilities of the two tribunals doesn't seem to be a very coherent arrangement. It would seem that the fact that decisions about treatment for people under the mental health legislation are being made by the Guardianship Tribunal in some cases and by the Mental Health Tribunal as they arise in other cases. It doesn't seem a coherent arrangement to me.[64]

The Committee noted with interest evidence presented to it that this concept of a linked operation of the Guardianship and Administration Board and the Mental Health Tribunal is unique to Tasmania.[65]

There was specific criticism of the *Guardianship and Administration Act 1995* from Advocacy Tasmania, which stated in its written submission that-

> The Tasmanian *Guardianship and Administration Act* 1995 (*GAA)* is a dated piece of paternalistic legislation which gives scant regard to a person's capacity to make or convey a decision except in the area of Consent to Medical Treatment.[66]

The organisation went on to elaborate on this criticism by suggesting that-

> Advocacy Tasmania could detail extensively the problems associated with the philosophies and powers of the GAA however it believes that such detail is unnecessary. The paternalism of the GAA has long been out of step with international and domestic trends regarding the rights of people with disabilities but now it is in contravention of international law. Advocacy Tasmania will be lobbying to have the Act reviewed/repealed/amended as a matter of urgency to reflect the legal rights of people with psychiatric disabilities who have the mental capacity to have their autonomy as a citizen of this state to make their own decisions respected.[67]

Ms Smith and Ms Rigby had a differing view of guardianship in Australia stating-

> In its Australian incarnation, guardianship has grown to a holistic response to decision-making disability extending to accommodation, health care, relationships and estate management. Guardianship laws apply a broad definition of

[64] Dawson, Professor John, *Transcript of Meeting* via phone link, 18 June 2009, pp. 3-4.
[65] McSherry, *Transcript of Meeting, op. cit.,* p. 34.
[66] Advocacy Tasmania Inc, *op. cit.,* p. 12.
[67] *Ibid.,* p. 16.

> 'disability' which encompasses people with mental illness and which arguably replicate the effects of mental health laws… The hurdle to mental health being absorbed into incapacity systems has been, in most jurisdictions, the inclusion of mental health laws of persons found not guilty by reason of insanity or unfit to plead… such persons should not be included in a civil mental health framework as their inclusion only serves to increase the stigma and discrimination attached to mental illness and the perception that it is linked to dangerousness.[68]

A possible change suggested in a paper by Professor Dawson and Dr George Szmulker, titled *Fusion of Mental Health and Incapacity Legislation*, was that-

> Reliance on incapacity criteria would shift the focus away from potential 'risk of harm' as the central ground upon which psychiatric treatment may be imposed. This shift is likely to have two main consequences. First, it might permit earlier intervention, in both physical and mental illness, because intervention would be authorised as soon as the patient lacked capacity to determine treatment, whether or not there was an imminent threat of harm. That approach is likely to find support with many patients' families. Second, reliance on incapacity criteria would permit uniform application of the criminal law: those who harmed others – or attempted to do so – could be controlled through the criminal justice system if they retained capacity, whether mentally disordered or not; whereas those who lacked capacity could be managed under comprehensive involuntary treatment legislation, whether 'dangerous' or not.[69]

Some evidence presented to the Committee suggested that the *Alcohol and Drug Dependency Act* was, in practice, used very infrequently and was also effectively outdated.[70]

Another witness highlighted a specific example of this weakness in the legislation, pointing out that-

> …there is effectively no legislative scheme in current usage for the rights or wellbeing of people with addictions. This group is specifically excluded from the provisions of the *Mental Health Act* unless there is also a mental illness.[71]

The written submission from Ms Smith and Ms Rigby further quoted from the research of Campbell and Rosenman regarding the matter of separate mental health legislation-

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[68] GABMHT, *op. cit.,* p. 31.
[69] Dawson, Professor John and Szmulker, Dr George, "Fusion of Mental Health and Incapacity Legislation," *British Journal of Psychiatry* (2006) 188: 504, p. 504.
[70] Advocacy Tasmania Inc., *op. cit.,* p. 7; GABMHT, *op. cit.,* p. 8.
[71] Schneider, *Written Submission, op. cit.,* p. 1.

> Campbell argues that having mental health laws separate to guardianship laws reinforces community stereotypes of people with mental illnesses…. Rosenman indicates that having two streams is inconsistent and ineffective…[72]

It was suggested that one means of overcoming the problems of four pieces of associated legislation that overlap in both responsibilities and operation would be to develop a single legislative framework to replace them.
This issue is discussed in more detail later in the report. However, at this point it is worth noting the evidence from Professor Dawson that-

> It is an ambitious proposal to suggest that one framework could cover the full range of issues for substitute alternative decision making for people with disabilities. If one were to think of a full legislative framework that would cover property issues, personal care issues and voluntary treatment issues this would be a very comprehensive kind of legislative framework.[73]

The Committee also notes that the Tasmanian Government has expressed an intention to review all of the acts relevant to this sector over the next few years.[74]

PROBLEMATIC CONCEPTS

Evidence presented to the Committee about the Tasmanian legislation drew attention to problems with definitions and the key concepts which underpin the way the legislation operates.

The most basic definition that caused concern was the meaning of the term 'mental illness'.

As mentioned above, mental illness is defined in the *Mental Health Act 1996* as follows-

"mental illness" means –

(1) A mental illness is a mental condition resulting in –

(a) serious distortion of perception or thought; or
(b) serious impairment or disturbance of the capacity for rational thought; or
(c) serious mood disorder; or
(d) involuntary behaviour or serious impairment of the capacity to control behaviour.

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[72] GABMHT, *op. cit*, p. 21 citing Campbell, T., 'Mental Health Law: Institutionalised Discrimination' (1994) 28 *Australian and New Zealand Journal of Psychiatry* 554, Campbell, T and Heginbotham, C., *Mental Illness Prejudice, Discrimination and the Law Dartmouth*, Aldershot (1991) and Rosenman, S., 'Mental Health Law: An idea whose time has passed?' (1994) *28 Australian and New Zealand Journal of Psychiatry* 560, p. 564.
[73] Dawson, *Transcript of Meeting, op. cit.,* p. 1.
[74] Tasmanian Government, *op. cit*., p. 15.

(2) A diagnosis of mental illness may not be based solely on –
- (a) antisocial behaviour; or
- (b) intellectual or behavioural nonconformity; or
- (c) intellectual disability; or
- (d) intoxication by reason of alcohol or drug.[75]

A number of people who gave evidence suggested that there were some inherent flaws in this definition. One even went so far as to suggest that mental illness "… defies adequate, consistent or useful definition."[76]

A similar view was put in a written submission by an advocate for people with mental illness who suggested that-

> Variously applied by professionals and the public, the concept of mental illness remains vague, incoherent and, thereby, open to ideological manipulation and abuse.[77]

Dr Eric Ratcliff, representing the Tasmanian Branch of the Royal Australian and New Zealand College of Psychiatrists stated-

> … the definition in the act of mental disorders which in the current act excludes alcohol and drug-related mental disorders. The problem about that is that comorbidity is the order of the day now, and often in an acute psychiatric situation it is difficult to know whether this is a drug-related one or a mental illness in its own right, or some mixture of the two. Therefore the definition of mental illness for the purposes of the act should include mental disturbance which may be due to alcohol and drug use. If that can be excluded by reasonable assessment within a reasonable time, perhaps it might only relate to the initial order, not necessarily to a continuing order.[78]

Dr Ratcliff was of the view that those presenting with personality disorders were also excluded under the current Act. He stated-

> If they have a personality disorder which from time to time produces manifestations more like a mental illness, I think they should come under the provisions of the act. But I think it would be inappropriate for them to come under, say, community treatment divisions and be placed under the act long term. Certainly it is appropriate for them to perhaps be involuntarily admitted in certain circumstances until we are sure what is going on. In other words, a diagnostic assessment period would be appropriate.[79]

Evidence from Tasmania Police also highlighted problems with the definition of mental illness. Inspector Mark Mewis told the Committee that-

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[75] Definitions, *Mental Health Act* 1996
[76] Mental Health and Guardianship & Administration Representation Scheme, *op. cit.,* p. 12.
[77] *Ibid*., p. 3.
[78] Ratcliff, Dr Eric, *Transcript of Evidence*, 23 March 2009, p. 33.
[79] *Ibid*., p. 34.

> … one of the issues with current legislation is that the mental illness definition is so defined that it does not take into account people who are suicidal, and that would probably be one of the main scenarios that we deal with on a regular basis.[80]

Inspector Mewis also said that, in relation to this definition, 'there are problems with things such as addiction to alcohol and drugs.'[81]
He told the Committee that-

> The current definition talks about a person who doesn't fit within the definition of mental illness based on alcohol or drug intoxication alone but sometimes if there are drugs or alcohol involved then that would seem to be a factor in determining that they don't have a mental illness, even though they previously have been diagnosed with a mental illness. Our knowledge of that would mean that we would be in a better position to argue the fact that just because they are intoxicated on this occasion doesn't necessarily mean that it's not a mental illness that is still playing a fairly significant role in this event. …. What can happen, for example, is that there will be a subject who police know has previously been diagnosed with a mental illness, perhaps on a number of occasions, and is involved in an event that could be seen as bizarre behaviour or whatever, but also happened to be drunk at the time. Our argument is that the drunkenness should not preclude the fact that they perhaps still need an assessment, depending on what they are doing.[82]

The Police Association of Tasmania also gave evidence in relation to deficiencies in the definition of mental illness.

Association President, Mr Randolph Wierenga told the Committee that-

> I am not sure how you are going to address the actual working on the coalface, but certainly the definition of mental illness or the ability to detain people for their own safety needs to be broadened to some degree so that the sad as well as the mad can get some treatment.[83]

Evidence received from New Zealand suggested a solution to this universal problem of defining mental illness. The definition of "mental disorder" in the New Zealand *Mental Health (Compulsory Assessment and Treatment) Act 1992*, is as follows-

> Mental disorder, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature),

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[80] Mewis, Inspector. Mark, Tasmania Police, *Transcript of Evidence*, 19 March 2009, p. 3.
[81] *Ibid*., p. 9.
[82] *Ibid*.
[83] Wierenga, Mr Randolph, *Transcript of Evidence*, 19 March 2009, p. 35.

> characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it –
>
> (a) Poses a serious danger to the health or safety of that person or of others; or
>
> *(b)* Seriously diminishes the capacity of that person to take care of himself or herself; -
>
> And mentally disordered, in relation to any such person, has a corresponding meaning.[84]

Professor Dawson provided some detail-

> The only way that we address such cases in New Zealand is by the inclusion of the disorder of volition in our list. It is a controversial matter that a disorder of volition can constitute a mental disorder of a necessary kind. On occasions that criterion or disorder of cognition applying to very unusual thinking… They will be stretched to cover such persons. … I prefer that kind of approach whereby you occasionally stretch the criteria to cover extreme cases rather than trying to formulate an actual definition of personality disorder included in the legislation because that then runs out of control.[85]

A number of parents and carers also gave evidence to the Committee about problems with the definition of mental illness being too narrow and strictly interpreted by hospitals and mental health professionals.

One parent, for example, told the Committee about their son-

> It took quite a while to come up with what you would call a diagnosis. Then, and now, he did not fit into the five major categories of mental illness. He is not psychotic. I guess his condition is extreme chronic anxiety verging on panic attacks every minute of every day, with obsessive compulsive behaviour, and probably in more recent times an extreme degree of paranoia. …. The interpretation of the act that is being used is that the only mental illnesses are the five major categories of mental illness that are easily treatable. I cannot even name them all, but schizophrenia and bipolar and depression are included. The way that the hospital and the crisis line are dealing with the calls and the visits to the hospital is that people like [him] are not mentally ill.[86]

Professor Oakley Browne agreed that there is variable interpretation of the Act, but argued that-

> It would be unusual that you would see someone with a personality disorder who at the time does not also meet some other criterion for a mental disorder. Quite commonly people with personality

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[84] *Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ)
[85] Dawson, *Transcript of Meeting, op. cit.,* p. 6.
[86] Private Witness 1, *Transcript of Evidence*, pp. 8 &12.

> disorders also will meet criteria for mood or anxiety disorder or substance-use disorder, and it is within the context of a life stress or difficult circumstance that you get self-destructive behaviours. In those circumstances I think you would look at the act and see if they met the criteria and I would be surprised if most people did not.[87]

The issue of comorbidity related to mental illness and alcohol and other drug abuse was highlighted by many witnesses. The issues associated with those who have addictions not 'fitting' under the current MHA has been compounded by a significant increase in the number of people presenting with comorbidity of mental illness and addictions.

Dr Paul Pielage, Director of the Department of Emergency Medicine at the Launceston General Hospital, stated-

> We get a lot of mental health patients and we also have people with drug and alcohol problems which often overlap. There is often a combination of the two issues in the same patient. The numbers increased rapidly in the early years of this decade and have been very stable the last four years. It has not changed at all….Numbers are always a little bit rubbery because of the way you define what is mental health, drugs and alcohol. It went up about 60 per cent between 2000 and 2005 but has remained constant ever since. Most of the patients turn up outside normal office hours - in other words, only about 30 per cent of patients turn up between 9 a.m. and 5 p.m. Monday to Friday.[88]

Dr Maharajh stated-

> With regard to the LGH and the north, certainly it is problematic. I think the one particular issue about it is the use of drugs and alcohol and historically there has been a pedantic rule of the blood alcohol level being less than 0.05 before Mental Health can be called in…. We are trying to bring some commonsense into that now. We have a new policy that is in draft and should be in place in a few weeks about police attendance at DEM and how we as mental health and clinical staff in general look at this in a commonsense, practical and logical way so that if someone comes in, even if the level is above 0.05, we are now able to work with clinical staff who might give an assessment… If we cannot assess them the DEM has the containment policy that will allow them to protect and look after the client and in a while to make the medical assessment and wait for the blood level to lower so they are in a position to attend to an assessment.[89]

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[87] Oakley Browne, *op. cit*., p. 16.
[88] Pielage, Dr Paul, *Transcript of Evidence*, 23 March 2009, p. 3.
[89] Maharajh, *Transcript of Evidence, op. cit*., pp. 5-6.

Dr John Crawshaw, CEO Mental Health and Statewide Services, Tasmanian Department of Health and Human Services, stated-

> Drugs have been an issue. I would have to say that if you put alcohol and drugs together throughout my practice lifetime a significant proportion of my time has been spent assisting people with their self-medicants of various forms. It has shifted from severe alcohol use through cannabis and other drugs subsequent to that time. We know all this affects their mental illness and their capacity to manage their illness and increases the chance of their being impaired in their decisionmaking…
>
> We know that ketamine and LSD will precipitate a psychosis in someone who has not previously been predisposed. For others the drugs are likely to aggravate a pre-existing condition. For others who have, say, mood disorders, drinking alcohol can make a significant impact in terms of their propensity to aggravate their mood disorder. So, yes, you are right. Alcohol and substances will interact with mental illness, sometimes quite adversely.[90]

Professor Jeff Malpas, Professor of Philosophy and ARC Professorial Fellow at the University of Tasmania, believed that-

> The whole area of personality disorder was a difficult one. Many of our youth mental health issues would fall into the category of personality disorder. Remember that many of these categories are not well defined. One psychiatrist in Melbourne said to me that there is a tendency - partly because of Beyondblue and similar programs - to diagnose everything as bipolarity, including many personality disorders, because you can treat bipolarity. You put them on lithium. That will not do very much for a personality disorder.[91]

INFORMED CONSENT AND CAPACITY

Another fundamental concept that can create problems for those helping the mentally ill is that of informed consent and the capacity to give informed consent.

It was suggested to the Committee "… that this issue of informed choice is a critical part of the legislation."[92]

The Committee was also told that-

> Tasmania actually leads the world in some areas compared to other jurisdictions in Australia. There are only two ways in the

[90] Crawshaw, Dr John, *Transcript of Evidence*, 12 February 2009, p. 95.
[91] Malpas, Professor Jeff, *Transcript of Evidence*, 13 August 2009, p. 15.
[92] Carlisle, Mr Patrick C., *Transcript of Evidence*, 12 February 2009, p. 84.

> Mental Health Act that a person can be treated and that is with their consent or through an order of the Guardianship Board.[93]

In relation to consent, it was argued that, while the law was clear, the interpretation and practice of that law was not.

Mr Martin Gibson, representing the Tasmanian Council of Social Services, told the Committee that-

> The current law is reasonably clear. Section 5AA does say that before any treatment can be provided there needs to be informed consent and the person needs to be capable of making that decision but it would appear that in practice there is a divergence. It's perhaps one of those lack of clarity issues in our current system.[94]

Much of the evidence about the problems with the meaning of informed consent revolved around the question of a mentally ill person's capacity to give their informed consent for treatment.

Some, like Mr Gibson, believed that "…there is a lack of clarity in relation to capacity issues."[95]

Others believed there should be caution in assuming that people with severe mental illness actually have the capacity to give informed consent. Psychiatrist, Dr Rosemary Schneider, for example, said-

> I think the issue of capacity in mental illness is very difficult. In my submission I looked at this question of insight and self-awareness in mental illness. In a large number of the most severe illnesses that is inherently lost. …. Those severe mental illnesses totally change people's whole outlook on life, which is usually driven by delusional beliefs and things like that. I think that to give them the right to make delusional decisions is totally inappropriate.[96]

Dr Schneider went on to say that-

> The key thing that we end up arguing at the moment with the tribunal is about capacity. If a person does not accept that they have mental illness then how can they make a reasoned decision about things like the adverse effects versus the benefits of treatment? …. The thing about capacity is that it can be a very articulate person who cognitively does not have any impairment but whose thoughts are guided by delusions. …. Our patients have the reasoning power in every other respect; their only blind spot is their

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[93] Williams, Ms Valerie, *Transcript of Evidence*, 12 February 2009, p. 28.
[94] Gibson, Mr Martin, *Transcript of Evidence*, 12 February 2009, p. 71.
[95] *Ibid.*
[96] Schneider, Dr Rosemary, *Transcript of Evidence*, 12 February 2009, p. 2.

> own illness. So if you are talking about capacity it needs to be very clear that you will include that aspect of capacity.[97]

Professor Dawson put a similar view to the Committee, stating that-

> I think you have to be careful if you are going to rely on a capacity test as the foundation for all intervention to have a sufficiently flexible capacity test. I think it has got to cope with some of the subtle forms of incapacity that people with mental disorder present - subtle forms of delusion and denial of illness and rapidly fluctuating capacity states and so forth. I think we have to have quite a flexible capacity test and it might want to contain an element of appreciation; a person should appreciate the need for treatment or something of that kind to cover situations of denial and lack of insight that is characteristic of mental disorders.[98]

A slightly different perspective was presented by Dr John Crawshaw, who told the Committee that-

> My view, and this is where I have had debates with others, is that the nature of mental illness is that there is some level of enduring incapacity but there are also people with fluctuating levels of incapacity, and it is the fluctuating levels that you need to craft additional responses around.[99]

This question of informed consent and the capacity of patients to give consent, leads inevitably to the issue of involuntary treatment, which lies at the core of the rights of the mentally ill person.

The difficulty in these situations was summed up by Mr Gibson who told the Committee that-

> If the person does have capacity I suppose one of two things can happen. Either they agree to treatment and that is simple, you provide the treatment. If they refuse treatment clearly it gets more interesting. There is considerable debate about what happens at that point. Some people say in most medical situations that is the end of the matter. It does not matter if you are going to die or whatever you can refuse medical treatment. There is another perspective that, in this situation, that refusal may be unreasonable because of the risk to that person's safety or the safety of other people.[100]

Mr Gibson added that-

> The determination of capacity needs to be the first step. My other comment is that under current Tasmanian law there is no capacity

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[97] *Ibid*., p. 6.
[98] Dawson, *Transcript of Meeting, op. cit*., p. 4.
[99] Crawshaw, *Transcript of Evidence*, 12 February 2009, *op. cit*., p. 88.
[100] Gibson, *op. cit.,* p. 72.

> for reasonable refusal of psychiatric treatment. The Mental Health Act under section 32(2) provides that if you have a mental illness, treatment has been recommended and the person has refused or is likely to refuse treatment they can be given the treatment in their own interest or for the protection of others.[101]

The Mental Health Council of Tasmania told the Committee that the community debate about involuntary treatment had not taken place. Ms Michelle Swallow, representing the organisation, said that-

> To then be told that you will receive this treatment against your will - as you said, someone with cancer is not necessarily made to do that - at what point does the community accept that it is okay for someone to force treatment on a human being for their greater good or for the community's greater good? I don't know that that robust debate has happened in a way that's really included a lot of thought behind it in terms of the capacity that I have, even if I have a mental illness, to make that decision for myself that no, I don't want this treatment.[102]

In its written submission, the Tasmanian Government was very clear in its position on involuntary treatment, stating-

> It is important to note that the provision of treatment to a person against their will is a serious violation of the person's autonomy and fundamental right to liberty. As such, legislative powers authorizing treatment and detention need to be prescriptive and definitive. The threshold that applies before a person with capacity should be compelled to receive treatment needs to be of the highest order.[103]

A similar view was put in the written submission from Anglicare Tasmania, which told the Committee-

> Anglicare has very grave concerns about any proposals for involuntary treatment of mental health consumers who have the capacity to consent (or refuse their consent) to treatment, unless in emergency circumstances…. there needs to be much more rigour around the criteria for any involuntary treatment.[104]

One witness who cared for a partner with a mental illness told the Committee that-

> Personally I don't think they should be forced to take treatment. I think, from my own experience over the five or six years, that with

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[101] Gibson, *op. cit.,* p. 72.
[102] Swallow, Ms Michelle, *Transcript of Evidence*, 12 February 2009, p. 36.
[103] Tasmanian Government, *op. cit.,* p. 5.
[104] Anglicare Tasmania, *Written Submission*, LCSC/MHL/15, p. 9.

> the right attitude from the professionals dealing with them they can be convinced to take the medication. That is what I found.[105]

Support for this position came from mental health professionals, including Dr Maharajh, who told the Committee that-

> Research has shown that coercive treatment does not work and that using the Mental Health Act is usually in the longer term not productive. Short-term use to contain risks is useful but in the longer term it does not allow the person to take responsibility for themselves.[106]

A more cautionary note was presented by Dr Eric Ratcliff, representing the Tasmanian Branch of the Royal Australian and New Zealand College of Psychiatrists, who told the Committee that-

> When people are admitted involuntarily they're often not in a condition where they can make a reasonable judgment about what's best for their own body. One of the problems is that when somebody is acutely ill they're certainly not thinking of what the detriment to them will be over the next 20 or 30 years. In the case of an illness like schizophrenia and to a lesser degree bipolar disorder a person may come to very serious harm down the track as a result of a misjudgment made at the outset. There is now very good evidence about the importance of early treatment, particularly in schizophrenia, for the ultimate outcome. So a short-term enunciation or an absolute principle that people have that absolute right is very much against their interests.[107]

Also relevant is the impact of privacy legislation as it can restrict the information that is available to concerned parties.

Professor Malpas explained that-

> I think the privacy laws are an enormous complicating factor here. They are a complicating factor here both in terms of trying to shift responsibility back onto institutions, off individuals, and they are a problem too in terms of trying to establish a broader as it were whole-of-environment or whole-of-question approach that … incorporates families into the equation. At the moment you cannot do that because the privacy laws prevent you from doing it.[108]

The development of an appropriate and effective test to determine capacity is a vital component of a capacity based legislative framework. This is not without its challenges and would require clear practice guidelines. The Yukon Health and Social Services 'Practice Guidelines for determining Incapability to

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[105] Private Witness 2, *Transcript of Evidence*, p. 30.
[106] Maharajh, *Transcript of Evidence, op. cit.,* p. 25.
[107] Ratcliff, *Transcript of Evidence*, *op. cit*., p. 32.
[108] Malpas, *Transcript of Evidence, op. cit*., p. 17.

Consent to Health Care and Need for Financial Protection Under the *Care Consent Act*', provides some direction in this area. A critical part of obtaining consent under this Act and guidelines is in the determination of whether a person is mentally capable to consent.
According to this document, the *Care Consent Act* sets out the test for incapability. Under the *Care Consent Act* "a person of any age can consent to their own care as long as they are capable of making that decision".[109] The Practice Guidelines provide the following advice under the heading, 'The Legal Test of Incapacity'-

> The determination of whether a person is incapable to consent to health care is a legal assessment (i.e. whether the person has the legal right to make their own decision). This is different than a clinical assessment where the health care provider is assessing the health needs and treatment options. However, health care providers use their clinical skills (e.g. interviewing techniques) in the legal assessment of whether a person is incapable to consent.
>
> The Act requires that the health care provider base the determination of incapability on whether or not the person demonstrates that he or she understands:
> - the information given by the health care provider about the person's health condition and the proposed treatment (see section 5. (v))[110]; and
> - that the information given applies to the person's situation.
>
> In other words, does the person understand and appreciate the consequences of their decision?[111]

However, it is clear from this and other evidence that the concepts of consent, capacity and involuntary treatment have implications for both the rights and wellbeing of people with psychiatric disabilities and/or addictions. The relationship between these concepts and the issue of human rights is considered later in this report.

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[109] Yukon Health and Social Services, Practice Guidelines for Determining Incapability to Consent to Health Care and Need for Financial Protection – Under the Care Consent Act, p. 5.
[110] *Ibid*., Section 5 – "A **valid consent** must meet the following test:
The consent must relate to the proposed care.
The consent must be given voluntarily.
The consent must not be obtained by fraud or misrepresentation.
The person must be capable of making a decision about whether to give or refuse consent to the proposed care.
The person must be given the information a reasonable person would require to understand the proposed care and to make a decision, including information about:
The reasons why the care is proposed;
The nature of the proposed care;
The risks and benefits of receiving and not receiving the proposed care that a reasonable person would expect to be told about, and
Alternative courses of care.
vi) The person must have an opportunity to ask questions and receive answers about the proposed care and the alternatives" - Practice Guidelines for Determining Incapability to Consent to Health Care and Need for Financial Protection Under the Care Consent Act, Yukon Health and Social Services, May 2005.
[111] *Ibid*., p. 8.

CONCLUSIONS

The Committee concludes that -

1. The current suite of protective legislation that is intended to protect the wellbeing and rights of those with mental illness requires comprehensive review.

2. Legislative powers authorising detention and involuntary treatment must be definitive and prescriptive with a threshold for involuntarily treating a person with capacity being of the highest order.

3. Legislative reform is required to address the rights and wellbeing of people with addictions.

4. It is imperative that an order to detain must also enable a capacity to treat.

5. Determination of an appropriate capacity test is a necessary component of any legislative reform.

6. There is a link between the use of drugs and alcohol, and mental health disorders.

Chapter 3 – DOES TASMANIAN LEGISLATION MEET BEST PRACTICE STANDARDS?

Many overseas jurisdictions have conducted reviews of mental health legislation to gauge effectiveness and to determine areas in need of improvement. European jurisdictions, in particular, have been thorough in their examination of best practice and the Committee is grateful to have had the Millan, Mason, Richardson and Bamford inquiries brought to their attention.[112]

The Northern Ireland Bamford Committee inquiry's vision was to value-

> … those with mental health needs or a learning disability, including their rights to full citizenship, equality of opportunity and self determination. The vision also look[ed] to a reform and modernisation of services that will make a real and meaningful difference to the lives of people with mental health needs or a learning disability, to their carers and families. It emphasis[ed] promoting the mental health of the whole community through preventative action.[113]

The Committee agreed, in principle, with the Overarching Recommendations of the Bamford Review and they have been included in Appendix 1.

The Committee received evidence relating to some areas where world's best practice can be identified. These were human rights, the role of official visitors, the process of review, representation/advocacy and the use of advance directives.

HUMAN RIGHTS

> Australia recognizes that every person with disability has a right to respect for his or her physical and mental integrity on an equal basis with others. Australia further declares its understanding that the Convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is necessary, as a last resort and subject to safeguards.[114]

This United Nations "Convention on the Rights of Persons with Disabilities" declaration, signed by Australia on 30 March 2007 and ratified on 17 July 2008[115], provides a strong basis for ensuring adequate protection for the rights

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[112] Abel, Mr Tony, *Transcript of Evidence*, 12 February 2009, p. 44.
[113] The Bamford Review of Mental Health and Learning Disability, *op. cit.,* p. 3(1.2)
[114] Australian Declaration from http://www.un.org/disabilities/default.asp?id=475 as cited in Mental Health and Guardianship & Administration Representation Scheme, *Written Submission*, *op. cit.,* p. 20.
[115] McSherry, Professor Bernadette, "Opening minds not locking doors", Rethinking Mental Health Laws, 50th Anniversary Public Lecture, 9th October 2008, Educate08, Monash University, p. 12 accessed at http://www.law.monash.edu.au/rmhl/docs/bmcs-educate08-openingminds.pdf.

and wellbeing of people with psychiatric disabilities and/or addictions and their families.

The Committee met with Professor Bernadette McSherry, an Australian Research Council Federation Fellow from the Rethinking Mental Health Laws Project, Faculty of Law at Monash University. Professor McSherry discussed the importance of the UN Convention declaration, outlined above, in terms of the rights on those with a mental illness-

> …with the UN convention there's much more of a trend now towards supported decision making, so in substitute decision making the guardianship model is always the last resort. With supported decision making, as in the Scottish model, there is much more emphasis on named persons to help the individual, plus a right to advocacy and carer involvement, and so on, so a lot of support for making a decision and then your substitute decision making is very much the sort of last resort trying to get people to voluntary treatment as much as possible.

The State Government submission stated that "…the current *Mental Health Act* was drafted with a human rights focus", however, it was acknowledged that its "… utilisation has not always reflected this reality."[116]

> There is a need for greater clarity around the statutory rights that consumers have, including in relation to the information to be provided to consumers, carers and their families, the right to an interpreter and legal support and the capacity to access records about their care and treatment, and for a general approach that is consistent with a consumer-centred approach …[117]

Professor McSherry explained that-

> The human rights debates concerning mental health have traditionally focused on the rights to liberty and autonomy in relation to the involuntary commitment of those with very serious mental illnesses. It has only been relatively recently that any discussion on the right to health and the associated right to access health services has carried over to the mental health arena.[118] Such a discussion may have the potential to reinvigorate the search for mental health laws that can aid access to treatment.[119]

Professor Malpas pointed out what he believed was a key point in the 'rights' debate-

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[116] Tasmanian Government, *op. cit.,* p. 21.
[117] *Ibid.*
[118] See eg Gostin L and Gable L, "The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health" (2004) 63 *Maryland Law Review* 20.
[119] McSherry, Professor Bernadette, "Mental health and human rights: The role of the law in developing a right to enjoy the highest attainable standard of mental health in Australia" (2008) 15 *Journal of Law and Medicine*: 773, p. 774.

> … much of our discourse has focused on individual rights but it is often a very narrow conception of rights. For instance, it seems to me one of the rights we do not talk about much is the right not to be made vulnerable to predatory business, let us say; the right not to be placed in a situation where your own interests are not well guarded. In dealing with Centrelink it seems to me that many people suffering from mental health issues ought to have an expectation, if not a right, that that organisation will try to deal with them in a way that safeguards their interest. I do not think that right is currently being upheld in any real sense. So I would suggest that if we are going to use the rights-based discourse, we need to broaden the conception of what those rights might be but at the same time I think we need to be very careful how we use the notion of a right. There is a deep inconsistency within many of our attitudes in our legislation in terms of the way we think about the notion of right. We do not assume that somebody has a right to drive a car without a seatbelt. We do not assume that somebody has the right to drive a car on the wrong side of the road. There are many areas where we do not see the notion of right overriding broader sets of responsibilities and broader issues even of individual protection.[120]

Witnesses who gave evidence to the Committee were supportive of the inclusion of human rights principles-

> … starting to look at human rights legislation or principles in this State really provides an opportunity to look at all our legislation from an individual rights and community rights point of view and I think that is really important.[121]

Ms Valerie Williams, on behalf of Advocacy Tasmania, is concerned that the Departmental review of the current legislation is being undertaken by clinicians and may not provide the range of perspectives necessary to safeguard some of these human rights issues. She advised the Committee that -

> There is also a huge movement in the human rights area, particularly with the European Court of Human Rights … that are being followed by countries that are required to follow them, such as the UK, and this is putting human rights principles into law. We are not legally required to follow these but they are very persuasive when we are dealing with issues around human rights. There are lots of issues around changes that are happening so when we do get a bill … one of the risks is the bill will be dated … at the time of implementation because the world will have moved forward in its understanding of human rights.[122]

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[120] Malpas, *Transcript of Evidence, op. cit.,* p. 3.
[121] Swallow, *Transcript of Evidence, op. cit*., p. 42.
[122] Williams, *Transcript of Evidence, op. cit*., p. 24.

Ms Therese Henning from the Tasmanian Law Reform Institute suggested that in any human rights instruments you should start with a baseline-

> … that these people are entitled to the same rights as everybody else in the community, and what you have to do is then frame everything in those terms. If you are going to encroach on that basic principle it has to be thoroughly justified, it has to be thoroughly hedged around with appropriate mechanisms that keep that as your fall-back position so that you have a constant review process built in to whatever encroachments on basic rights you're legitimising, so that you've got information rights, appeal rights and independent review rights and that you keep that review process going. You make sure also that whatever bodies are set up to interfere with rights don't work on a blanket policy and apply to everybody. You have to individualise everything and that's been one of the major outcomes of the application of the Human Rights Act in the UK to mental health processes and disability process. It has been that you make sure that departments and hospitals, mental health institutions or whatever, individualise whatever they do. They don't just have a blanket policy, for example, that we're not going to, when we admit people to our institutions, maybe an elderly couple and one of them is demented and the other one's not, just elderly and a bit disabled, that we don't say, 'right, we're going to separate the couple now; that is the end of their married life together. Men are in this wing and women are in that wing.' That was sort of a blanket policy that a number of institutions in the UK adopted and when the Human Rights Act came into play that was questioned and they said no, you have got to individualise this process.[123]

Ms Williams stressed the point that the Tasmanian Mental Health Act-

> …is there to protect people with mental illness because their rights to autonomy are being removed by the State so it is to really safeguard their rights when the State intervenes and it really only applies to people who are involuntarily detained...[124]

However, she further stated that, “there are virtually no human right safeguards in the Act including the right of review, to protect persons admitted to a treatment centre as involuntary patients or upon personal application, as voluntary patients.”[125]

Mr Ken Hardaker, also from Advocacy Tasmania, supported this view, stating that-

> It is a fact that the State, through mental health legislation, has the power to strip people of many of their rights, including the right not

[123] Henning, Ms Therese, *Transcript of Evidence*, 18 June 2009, pp. 18-19.
[124] Williams, *Transcript of Evidence, op. cit.,* p. 24.
[125] Advocacy Tasmania Inc., *op. cit.,* p. 7.

> to be detained for considerable lengths of time against their will. So we believe that this power must be tempered by very careful consideration of the circumstances under which such power is exercised and by the safeguards which need to be built in to protect the rights of those that are affected.[126]

Despite these concerns, Ms Williams acknowledged that Tasmania does lead the world compared to some other jurisdictions, particularly in the way a person can be treated.[127]

In other words, "… if you want to involuntarily treat in this State you have to get that permission from the Guardianship Board".[128]

Ms Danni Lane, an independent Mental Health Consumer Advocate, had similar concerns regarding the consideration of human rights and told the Committee that "…repeatedly over the lifetime of this current *Mental Health Act* there have been horrific abuses of human rights perpetrated against patients in State owned facilities…"[129] and that -

> Validation of this [belief] can easily be found in the fact that a mere 12 years after its introduction the government is intending to scrap the current Act in favour of a new revamped Mental Health Act; an Act which despite the original good intentions of the drafting and advisory committees is already being condemned by many for its draconian content and potential for further State sanctioned human rights abuses.[130]

Ms Lane was also critical of proposed reforms which allow for "forced medical treatment on non-consenting persons"[131] as it is a potential breach of Australia's duties under the UN "Convention on the Rights of Persons with Disabilities."[132]

The Mental Health Council of Tasmania provided some caution regarding a person's rights in its written submission to the Committee-

> Considering that autonomy and empowerment are important components for recovery, removal of an individual's right to choice regarding their own treatment is a serious issue that requires stringent parameters predicated on a holistic approach to recovery.[133]

Ms Sarah Hanson from the NSW Law Reform Commission commented-

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[126] Hardaker, Mr Ken, *Transcript of Evidence*, 12 February 2009, p. 22.
[127] Williams, *Transcript of Evidence, op. cit*., p. 28.
[128] *Ibid.*
[129] Lane, Ms Dannii, Independent Mental Health Consumer Advocate, *Written Submission*, LCSC/MHL/14, p. 1.
[130] *Ibid.*
[131] *Ibid.*
[132] *Ibid*., p. 2.
[133] Mental Health Council of Tasmania, *op. cit.,* p. 3.

> If you are going to make decisions about a person's lifestyle, finances and housing, there is a right to autonomy in that regard and there is no justification to encroach on that purely because of risk to the person, whereas there might be a justification to encroach on a person's right to choose or not choose a particular medical treatment if they pose a risk to others. The human rights framework really illustrates those things quite well.[134]

Victoria has implemented a Charter of Human Rights from 1 January 2008, which provided:

> … a timely opportunity in Victoria to comprehensively review the whole policy and legislative framework around the use and review of compulsion for treatment of people with a mental illness …[135]

The Tasmanian Law Reform Institute's report on *A Charter of Rights for Tasmania*, made the following recommendations relevant to mental health for inclusion in a charter for Tasmania -

- The right to equality before the law and to equal protection of the law;
- Freedom from discrimination; and
- The right to the highest attainable standard of physical and mental health.[136]

The Committee members, however, expressed some concern regarding the impact on the family and the rights of the family to determine that it is in the best interests of their loved one to receive treatment.

According to Professor Malpas-

> It is easy to throw up a rights argument and forget how much damage a rights argument can do. If we just think about families as one of the primary points of focus for relational connections that make us human, very often we are destroying those relationships and the capacity of those people to work together. We destroy them in lots of different ways. In a family where you have a child who gets into difficulty and where the family cares about that child, they will go into debt and the family itself will be destroyed. I know of lots of cases where what starts as a small problem becomes a bigger problem, and ends up not just taking that young person but also the whole family. Then you have the compounding of an individual mental health problem into a major social problem. A

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[134] Hanson, Ms Sarah, *Transcript of Meeting* via video link, 25 May 2009, p. 11.

[135] Lesser, Mr John, "Lessons from Abroad: Australian Mental Health Law and Practice in an International Context" – A Cross-Jurisdictional Evaluation of Involuntary Mental Health Legislative Frameworks, Treatment and Review Systems – A General Report for the Victorian and wider Australian Communities – 29 February 2008, p. 79 accessed at http://www.mhrb.vic.gov.au/documents/GeneralFinal29.02.08.pdf.

[136] Tasmanian Law Reform Institute, *A Charter of Human Rights for Tasmania*, Report number 10, pp. 2-3.

> good many of the broader social problems we have stem from our inability to deal with some of these individual problems. Some of them are from mental health issues. It is our inability to handle this relational aspect of our lives that is fundamental and we need to find better ways of addressing it.[137]

Professor McSherry also had difficulty with this issue-

> So it is where do you draw the line? In America, because they have had such a very strong human rights basis it is very difficult to get people into the system and some would argue they have gone too far the other way so that you have people … dying with their rights on; they are sitting on street corners and they could most probably benefit from treatment but it is their right to refuse it. Where you get that balance is very difficult but I think if you go on the principle that voluntary treatment is the default setting, and I think a lot more work needs to be placed on access to treatment and you can do that through laws, then have as your very last resort, okay sometimes we have to have this involuntary detention for treatment.[138]

It is a difficult issue and there appears to be no easy solution. Professor Malpas believes that-

> The reason it is not simple is that the characters of people are not constituted as autonomous beings. We are constituted by the relations we have with the people, places and environment around us. Mental illness obviously has physiological bases but it is also a dysfunctionality in the way we relate to others, ourselves and to our world. We cannot address those problems if we insist on not acknowledging that relationality and simply insist on individuals as autonomous humans. The other thing about individual right and choice is: which individuals are we talking about? When does one right or choice take precedence over another? We very often use the language of right in an overly simplistic way. To protect any individual's rights is always, as it were, to defeat the individual right or choices of others.[139]

OFFICIAL VISITORS

Official Visitors are considered "… a good mechanism in safeguarding the rights of people with psychiatric disability while influencing, monitoring and oversighting the development and delivery of best practices services …"[140]

The current *Mental Health Act* states that the functions of Official Visitors are-

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[137] Malpas, *Transcript of Evidence, op. cit.,* p. 8.
[138] McSherry, *Transcript of Meeting, op. cit.,* p. 24.
[139] Malpas, *Transcript of Evidence, op. cit*., p. 7.
[140] Advocacy Tasmania Inc., *op. cit.,* p. 3.

> (a) to examine the adequacy of the services for the assessment and treatment of mental illnesses in the region or in the approved hospital or secure mental health unit for which the official visitor is appointed;
>
> (b) to examine the appropriateness and standard of facilities for the accommodation, assessment, care and treatment of persons with mental illnesses in the relevant region, approved hospital or secure mental health unit;
>
> (c) to investigate the opportunities and examine the facilities for the recreation, occupation, education, training and rehabilitation of persons receiving care or treatment for mental illness in the relevant region, approved hospital or secure mental health unit;
>
> (d) to investigate any suspected contravention of this Act in the care or treatment of persons with mental illnesses and, in particular, unnecessary bodily restraint, seclusion or other restriction on freedom;
>
> (e) to visit patients and assess the adequacy of their care and treatment;
>
> (f) to investigate complaints made by persons receiving care or treatment for mental illness.[141]

Advocacy Tasmania suggested that Official Visitors can be effective in protecting the rights and wellbeing of people with psychiatric disabilities and/or addictions, however-

> … To date, this has not been the case in Tasmania primarily due to issues of governance and management, limited functional scope, an inadequate reporting stream, difficulty in recruiting and retaining Visitors and failure of government to appropriately structure and resource the Scheme.[142]
>
> …It is uncertain whether Official Visitors distinctly empowered under the Mental Heath Act is the best scheme for Tasmania considering amongst other factors the state's small population and its unique social and professional networks. An alternative to the MHA OVs is the creation of a Disabilities Visitor Scheme which would have safeguarding powers for all Tasmanians with disabilities including psychiatric disabilities that are in receipt of services, monitoring the delivery of services so as to ensure quality best practice standards are met by government, as well as private and NGO providers. Other alternatives might include a system of

[141] *Mental Health Act 1996*
[142] Advocacy Tasmania Inc., *op. cit.,* p. 3.

> independent mental health advocates or a unit of complaints investigators sitting within a new Office of the Public Advocate.[143]

Anglicare supports-

> …a wider role for Official Visitors in the interests of protecting the rights and well-being of people living with a mental illness, including a role in monitoring government-funded services delivered by community service organisations, and the capacity to have access to the full range of locations where people with mental illness are treated and to information about that treatment, and related matters such as incident reports.[144]
>
> We suggest that the necessary independence would be best supported by establishing the Scheme within the office of the Health Complaints Commissioner, or a similar independent statutory authority.[145]

The Guardianship and Administration Board states that-

> The role of official visitors with roving commission to monitor places where people with disabilities are accommodated and treated has been a fundamental tenet of the legal response to disability. Repeal of the mental health acts would mean that the role of official visitors would be repealed too. In the absence of official visitors there would still be the complaint based facilities of anti-discrimination commissions, health care complaints commissioners, ombudsman and the courts. However, it has always been recognized that people with disabilities may be inhibited from taking a complaint by their disabilities or by their dependence upon the agencies about whom they might complain. We recommend that consideration be given to inclusion of the official visitor role within capacity laws with the power to inspect not being based upon receipt of complaint…
>
> This proposal for a capacity agent to be appointed to make reasonable adjustments for the disability and incapacity of the person is sufficiently similar to existing guardianship models to be applied easily. The protection of human right requires the capacity agent being communicative, responsive and active in their role.
>
> With the removal of tests related to the 'risk' that a person with a disability might present to himself, herself or others, the stigma associated with having a mental illness or dependency might decline. Further the ability of one tribunal to consider significant personal and financial decisions (including decisions about

[143] Advocacy Tasmania Inc., *op. cit.,* p. 3.
[144] Anglicare Tasmania, *Written Submission*, *op. cit.,* p. 10.
[145] *Ibid.*

> hospitalization and treatment) enhances the law's ability to deliver a holistic response to deficits in decision-making.[146]

Dr Ratcliff was not convinced that Official Visitors were the appropriate people to undertake the required role. He cautioned that "the idea that everybody is hostile to [people with mental illness] except this nice person who holds their hand is a very troublesome thing".[147]

> …they are permitted for instance to view patients' records but they cannot understand what they are looking at, they do not understand what the issues are. I think having lay people in that sort of situation is a big hole in the privacy act; it is just not a good way to do it. It just looks a good way from the point of view of some advocacy groups who see that as having some sort of independence. Whereas in fact they may very well be independent but they are also in a degree of ignorance that is not appropriate to the work they are doing.[148]

Dr Ratcliff personally believed that the Mental Health Tribunal could operate continuously and undertake additional duties, including "…regular inspection of not only public facilities but also there should be an inspectorate of registered accommodation for the private and the voluntary sector, or non-profit sector, for where patients actually live".[149]

The State Government's written submission to the Committee provides some details of the changes being considered for inclusion in the new Mental Health Act.

> The proposed Mental Health Act will continue to feature the appointment, role and functions of Official Visitors by way of clarified and streamlined provisions. In particular, the proposed Mental Health Act will make it clear that Official Visitors have a role in relation to involuntary patients receiving treatment in the community.[150]

REVIEW PROCESSES

The Government submission provides details of Initial Orders, Continuing Care Orders, Community Treatment Orders, and also lists the functions of the Mental Health Tribunal, and these are included in Chapter 2 of this report.
When a person is placed on an Initial Order there is an interval before it is reviewed. Ms Rigby told the Committee that-

> There were well over 400 people actually put on orders, but then fewer than 200 of those were reviewed. In any given year we

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[146] GABMHT, *op. cit.,* p. 43.
[147] Ratcliff, Dr Eric, *Transcript of Evidence*, *op. cit*., p. 38.
[148] *Ibid.,* p. 39.
[149] *Ibid.,* p. 39.
[150] Tasmanian Government, *op. cit.,* p. 22.

> would review less than half of the people who are put on orders, and that is because those orders are discharged by the hospital and they are short term, so they are discharged before the 28-day hearing period. Once you take that away and you look at the small number that we actually looked at, you will see that these are normally people who are acutely unwell, whose belief systems are fairly seriously entrenched and, for some of them, unfortunately, they are treatment-resistant and so, medicated or not medicated, life is not going to get much easier for them. But for others medication makes an enormous difference to their daily functioning.[151]

She was concerned that it is impossible to accurately gauge if these orders are being used appropriately due to the fact that they often expire before the mandated review.[152] Ms Anita Smith and the Guardianship Board have had some concerns about the use of initial orders-

> They are meant to be an assessment order to assess whether a person requires treatment and to settle them down. In practice they are quite often used for someone who has been long-term in a facility and who evinces an intention on one particular day to go into town and maybe get drunk or something. They put an IO on the person who has been giving their view - they don't need assessment, they know perfectly what illness they have and what treatment they need. They put an IO on to stop them leaving at a time when the facility do not think it is appropriate for them to leave, which is complete misuse, and the board has actually published decisions about that. So for someone who has already been assessed and whose condition is thoroughly known, you put an initial order on them to stay in a facility where they have lived for five years. It is a complete abuse of process.[153]

She explained that effectively IOs get to "slip under the radar."[154] However, Ms Smith did agree that there was a need for some form of Initial Order-

> If you are walking through in the morning and see someone in absolute distress, you want someone to be able to pick them up and take them to hospital, so, clearly, that is needed. It is not a facility that currently exists under guardianship legislation so an incapacity model would need to have that. If you were to simply repeal medical effect, you would still need to keep that function in there but you would need an educative process about this being just for assessment and initial treatment, not for a long-term resident to be kept in - it is not a gate-keeping mechanism.[155]

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[151] Rigby, Ms Debra, *Transcript of Evidence*, 22 May 2009, p. 8.
[152] *Ibid*., p. 9.
[153] Smith, Ms Anita, *Transcript of Evidence*, 22 May 2009, p. 9.
[154] *Ibid.*
[155] *Ibid*., p. 10.

Ms Swallow advised the Committee further that in other Australian states-

> … there are different rates of review, different ways of dealing with somebody when they are psychotic or needing emergency or urgent intervention. It is not just around health, it is also to do with police and ambulance and it is working across government so there is a greater understanding of mental disorders and mental ill health and the effect that has on the person who is unwell, and their families and people who support them. How do you involve consumers' families and/or carers in a process if the person doesn't want that to happen? It is not part of the act, it is about really good policies and procedures that back up any piece of legislation.[156]

Professor Dawson believes that the review process "… is a really central issue and in my discussions with people in Victoria and New South Wales in 2003 about the operation of their Mental Health Act … [it] is how frequently reviews should be held under the act".[157]

Whilst Community Treatment and Continuing Care Orders are reviewed, it can be up to 28 days after their implementation, and "by this time, it is estimated that approximately two-thirds of Orders have been discharged (the average length of a Continuing Care Order is 13 days)."[158]

Evidence presented to the Committee supported the review of orders under both the Mental Health Act and Guardianship and Administration Tribunal as being a useful check to avoid arbitrary sanctions and limitations on people who are now capable of making decisions for, and looking after themselves. However, there was also a downside noted to this system of continuous review by Ms Smith-

> When we were talking before about continuing care orders that might not be renewed, there have been occasions when the Mental Health Tribunal has sat, heard an application in respect of someone who has been under continuous CCOs for many years - every six months they get their hopes up that they are going to be released - which is actually detrimental to their treatment and their wellbeing.
>
> At times, the Mental Health Tribunal has made a recommendation that there be an application for guardianship because then a review is every three years, as opposed to every six months, and causes a lot less distress, but we would be talking about five or six individuals who are very unwell.[159]

According to Ms Swallow, Mental Health Council of Tasmania, it can be-

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[156] Swallow, *Transcript of Evidence, op. cit.,* p. 39.
[157] Dawson, *Transcript of Meeting, op. cit*., p. 12.
[158] Tasmanian Government, *op. cit.,* p. 17.
[159] Smith, *Transcript of Evidence, op. cit*. p. 10.

> … very hard for [the Tribunal] to review why the decision was made. If you treat someone against their will and it goes before the tribunal for review because you have asked for that to happen, there is no requirement - if I am the treating physician or psychiatrist I don't have to tell you why I made that decision. That is a little archaic and is part of the current act.[160]

Dr Schneider provided a practitioner's view-

> One problem with the current Mental Health Act for these latter two groups [those who improve to a worthwhile extent with treatment, and those who remain actively ill despite treatment] is that the maximum duration of compulsory orders in no way matches the duration of their needs for compulsory treatment. There is a need to allow for an option of much longer orders, especially for in-patient treatment, such as two years instead of the current six months. It can cause quite unnecessary renewed anger for some patients to have to go through Mental Health Tribunal review every six to twelve months and hear the same arguments against their own wishes each time, presented by staff who otherwise are trying to keep some rapport with them.[161]

Dr Schneider recommended that "… compulsory orders of two years' duration should be available for those still needing in-patient care after a year on Continuing Care Orders, or after two years on Community Treatment Orders."[162]

Professor Dawson stressed that-

> Tasmania should be especially careful not to adopt a system of frequent, mandatory reviews before an under-resourced review tribunal. Nor should review proceedings be so onerous or time-consuming as to unduly discourage clinicians from using the compulsory treatment regime.[163]

He further suggested-

> I think a sliding scale of reviews is very useful whereby you have more frequent reviews early in the life of an order and then less frequent reviews later, but then you do not allow orders to become indefinite and triggered only by the action of the person who is disabled.
>
> Orders should always be time limited. One year is too long for the initial order. I think six months is the right kind of length for the initial order. Three months is too short - it goes by too rapidly and puts too much of a

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[160] Swallow, *Transcript of Evidence, op. cit*., p. 39.
[161] Schneider, Dr Rosemary, *Written Submission*, *op. cit*., p. 2.
[162] *Ibid.*
[163] Dawson, Professor John, Faculty of Law, University of Otago, *Written Submission*, LCSC/MHL/20, p. 1.

> burden on clinicians to renew the order after three months. Six months is about right but then it could be out to 12 months or two years with the passage of time.[164]

Professor Dawson supported the process in New Zealand-

> I tend to think that having a hearing after about a month … is a useful thing to do. Then an order that was made would be for six months. It might then be renewed for another six months perhaps or for a year and then it might go out to say two years but I do not think it should be much longer than that.[165]

The proposed changes to the Mental Health Tribunal were outlined, as follows-

> It is anticipated that the proposed Mental Health Act will establish a new Mental Health Tribunal. The proposed Tribunal will make decisions about the need for a person to be placed on an involuntary order, and about the treatment setting (such decisions are currently made by family members or clinicians). Enabling matters about treatment and treatment setting to be decided by one tribunal pursuant to a single piece of legislation will ensure independence of decision-making and provide greater clarity for consumers and clinicians, and provide a more effective and efficient use of resources than is currently the case. This will ensure that all decisions about a person's involuntary psychiatric treatment are made by a person who has been formally appointed to perform this role (a legally appointed guardian) and who is thereby subject to independent oversight [by the Guardianship and Administration Board], or by the Tribunal.[166]

And that-

> …The Tribunal will have responsibility for ongoing oversight and review of decisions around the need for involuntary treatment. This role is currently performed by the Tribunal, the Forensic Mental Health Tribunal, and/or the Board, depending on the nature of the matters to be considered. Specifically, the new Tribunal would review its initial decision around involuntary treatment and treatment setting after one month, and on a three-monthly basis thereafter. A person subject to an order would also be able to request a review at any time during the life of the order.[167]

As previously stated, the Minister has advised that the amendment legislation will not be introduced during the current term of this Government.

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[164] Dawson, *Transcript of Evidence, op. cit*., p. 11.
[165] *Ibid.,* p. 12.
[166] Tasmanian Government, *op. cit.,* p. 20.
[167] *Ibid.,* p. 22.

The written submission provided by the Guardianship and Administration Board and the Mental Health Tribunal suggests further amendments to legislation to provide appeal rights-

> The current Act is silent regarding appeal from a decision of the Tribunal. An express provision creating a right of appeal from a tribunal decision to the Supreme Court advances the rights of patients. Express appeal provisions increase the accessibility of appeal rights.
>
> The Act does not currently provide for the provision of reasons for decision by the Tribunal. The Tribunal has determined that this is not appropriate and currently issues reasons for decision upon request to parties to the hearing. It is not appropriate that such important information for the patient is not legislatively required. The amendment will significantly advance the rights of a patient to be fully cognisant of the matters the Tribunal has taken into account in making its determination.[168]

REPRESENTATION/ADVOCACY

The Government submission to this inquiry commented on Mr John Lesser's report, "Lessons from Abroad: Australian Mental Health Law and Practice in an International Context – a Cross Jurisdictional Evaluation of Involuntary Mental Health Legislative Frameworks, Treatment and Review Systems"[169] and concluded that "…the need for legal representation" was a non legislative reform. [170] Evidence suggested that-

> The record of the legal profession in providing meaningful advocacy services to mentally disabled person has been grossly inadequate'. He argues that sporadically appointed counsel are often unwilling to carry out the necessary investigations, lack the necessary expertise to deal with mental health problems, tend to capitulate to medical experts and are unable to generate professional or personal interest in the patient's dilemma. He reports that in jurisdictions where there is a regularized, organized system of legal service delivery, staffed with full-time advocates dedicated to the provision of legal representation to mentally disabled persons, then, lawyers play a critical role in the proceedings and in the way that the mental disability and justice systems interact.[171]

Mr Lesser's report recommended that the following be considered-

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[168] GABMHT, *Written Submission*, p. 13.
[169] Available online at http://www.mhrb.vic.gov.au/documents/GeneralFinal29.02.08.pdf
[170] Tasmanian Government, *op. cit.,* pp. 26-27.
[171] Perlin, M.L. (1992) 'Fatal Assumption: A Critical Evaluation of the Role of Counsel in Mental Disability Cases". *Law and Human Behaviour* 16(1): 39-59, p. 43 as quoted in Mental Health and Guardianship & Administration Representation Scheme *Written Submission*, *op. cit*., p. 8.

(a) establishing in legislation and recurrently funding at an appropriate level an independent patients' rights advice, advocacy and support service;
(b) providing increased levels of funding to facilitate higher levels of legal aid-funded legal representation at appropriate Board hearings;
(c) a specific legislative amendment to facilitate new members' involvement in hearings as part of induction training;
(d) providing increased funding to the Board to facilitate clerking services and an overall greater capacity to provide a higher level of administrative support for Board members at hearings;
(e) providing increased funding to the Board to ensure that listing practices are such that the maximum number of hearings that each Board division conducts per sitting facilitates more human rights-compliant, pro-therapeutic, high-quality and comprehensive review hearings than is currently possible;
(f) recognising the importance of mental health review processes by treating Board members as a separate but acknowledged element of the Victorian court and tribunal system;
(g) concurrently with giving effect to the recommendation in (f) above, changing the name of the Board to the "Mental Health Review Tribunal", and creating a legislative requirement for the President to fulfill the criteria for appointment as a legal member.[172]

However, not all agreed with this scheme. Dr Schneider remarked that the "use of lawyers in their professional capacity should be legislated against in Mental Health Tribunals..."[173] Although she did make it clear that forensic tribunals should be excluded from this categorisation. [174]

Ms Williams explained that-

> The Forensic Mental Health Tribunal is under Wilfred Lopes and is to do with people who are in a forensic criminal setting. As prisoners or on remand they are entitled to their lawyers, the same as if they were in the lower court or the Supreme Court. They have a right to legal representation, as do people appearing before the Mental Health Tribunal. It is a legal right. It is in our act and all the human rights instruments. There is no jurisdiction anywhere that says you can't have access. What you are talking about in the Mental Health Tribunal area is the deprivation of liberty for six months. If you were in the criminal court system appearing before a magistrate and there was a possibility that you would go to jail and be deprived of your liberty for six months, you would have a lawyer appointed by Legal Aid, if you couldn't afford one, and if you did not have one the magistrate would stop proceedings to ensure that you received legal representation if that was the outcome. These

[172] Lesser, "Lessons from Abroad" *op. cit.,* p. 7.
[173] Schneider, *Written Submission, op. cit*., p. 4.
[174] *Ibid.*

> people appearing before mental health tribunals can be locked up against their will for six months - in blocks of six months.[175]

One suggestion to remedy the injustice perceived by some in forcing some individuals to go unrepresented, was that-

> …the tribunals themselves should have the power to direct if they think someone needs to be legally represented, but the fallback should be that they're not. We had an interesting example yesterday of a quasi-lawyer representing someone who gave all sorts of coherent arguments on that person's behalf. The person was a bit thought-disordered and would have had great difficulty expressing all that as coherently. But that is part of the information about their ability to function that the tribunal would need to take into account. I think being able to hide behind a lawyer negates part of the purpose of what is essentially a question of medical treatment.[176]

Mr Lesser, however, argued that-

> …the best recommendation of all, and I think the Government will take this up, is the notion that representation is one element, but the other element is what I call rights advice. Victoria does that through the services and I don't think that's an appropriate way to do it. Every other jurisdiction I went to has a model of independent rights advice, so they have an organisation which is funded to come into the hospitals or deal with community patients and give them independent advice - about the act, the service delivery, about complaints, a whole range of advice. There are models in England, Scotland, the Netherlands, Ontario … and even Denmark has a reasonable model. … Scotland has quite a good model as well. Scotland has the best act by far in terms of drawing together what you'd call the current human rights issues, but in terms of the rights advice probably the most developed one is the Netherlands. … But in all those jurisdictions there is a right to legal representation as a matter of course, and it is paid for by the Government.[177]

His report stated-

> In respect of the conduct of hearings themselves, the high levels (over 95%) of legal representation in jurisdictions such as England, Scotland, Ontario and LA creates a two-edged sword. On the one hand, it fosters a far more robust review process, but on the other, at a considerable cost, not just in time, but also in effect on the informality and the non-adversarial nature of hearings. By contrast, in the Netherlands, judges completed legally represented hearings

[175] Williams, *Transcript of Evidence, op. cit.,* p. 30.
[176] Schneider, *Transcript of Evidence, op. cit*., pp. 10-11.
[177] Lesser, *Transcript of Meeting, op. cit*., p. 10.

> with the same efficiency and dispatch as the Victorian Board. At the end of the day, the different hearing systems employed did not seem to change the hearing outcomes in any significant way.[178]

The importance of advocates for individuals hospitalised due to a mental health issue was also examined by the Committee.

According to an article written by Dr Stephen Rosenman et al, "…nursing staff reported that personal advocacy made patient management easier …"[179] The article continued, stressing that "…analysis of variance indicated that personal advocacy was the most significant factor in the lower rehospitalisation rate in the experimental group …"[180]

The results of the trial of a group of people with a personal advocate throughout their hospital stay, indicated that-

> The effects of the personal advocacy approach were striking. Both groups were similar in demographic characteristics, diagnosis, and severity of illness. Before and after hospitalization, all subjects were approached identically by the health system; the clinicians responsible for aftercare rarely knew whether the subject had received personal advocacy. The type of advocacy was the only significant difference between the two groups.
>
> The most impressive findings were the experimental group's greater satisfaction and their lower rate of involuntary rehospitalization.[181]

Mr Tony Abel noted in his written submission that-

> …. independent advocates ensure that the vulnerable and disenfranchised have access to a capable voice able to articulate their wishes and perspectives. A legislative requirement that advocacy be provided at once recognizes and reinforces the right to individual autonomous decisions, and the impediments that many may experience in ensuring these are understood and heard. The absence of such provision in Tasmanian legislation, present and projected, is a major failing in terms of contemporary best practice.[182]

ADVANCE DIRECTIVES

The issue of the use of advance directives in the area of mental health treatment and management was noted as an important aspect of ensuring a degree of autonomy and control over treatment choices for people with

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[178] Lesser, Lessons from Abroad, *op. cit.,* p. 80.
[179] Rosenman, Korten and Newman, "Efficacy of Continuing Advocacy in Involuntary Treatment" *Psychiatric Services* (2000) 51 (8) 1029, p. 1032.
[180] *Ibid.*
[181] *Ibid.*
[182] Abel, Mr Tony, *Written Submission*, LCSC/MHL/2, p. 6.

diagnosed mental illness. Anglicare Tasmania's written submission highlighted the importance of considering the use of advance directives as a matter of priority.

> [The use of advance directives] is an issue of considerable interest in the field of mental health…. While advance directives have applicability in a range of areas, the episodic nature of much mental illness means that they are a tool with particular applicability in the mental health field, and may also have a role in addictions. Such a directive could cover matters of treatment options and who should be informed about a person's condition when they are unwell. While far from universally applicable and still with many complexities, advance directives can offer some safeguards to support autonomy and self direction and protect family relationships and offer clarity for medical practitioners and support workers in delivering appropriate services.[183]

TasCOSS agreed. Their written submission suggested-

> … legislation be considered that applies to a range of situations in which a persons capacity to consent and make decisions for themselves is likely to be in issue. Such legislation should address … The role of substitute decision making mechanisms, including advance directives – statements made by people when they have capacity, recording their wishes in relation to what should happen should they become unwell and lack the capacity to make informed decisions for themselves.[184]

CONCLUSIONS

The Committee concludes that-

7. There are areas within the current legislative framework that require review and amendment to ensure compliance with Human Rights Conventions.

8. An absolute principle or short term enunciation that people have an absolute right can be contrary to their best interests.

9. The frequency and timing of reviews of orders should be reviewed.

10. All persons with a mental illness should have access to an advocate.

11. Persons appearing before a Mental Health Tribunal or Guardianship Board Hearing should be entitled to legal representation.

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[183] Anglicare Tasmania, *Written Submission*, *op. cit.,* p. 12.
[184] TasCOSS, *Written Submission*, LCSC/MHL/17, p. 2.

12. The role of the Official Visitor is an important part of the oversight of mental health services.

13. Advance directives could provide greater autonomy and choice for persons suffering acute mental illness and subject to the provisions of current and future protective legislation.

Chapter 4 - IS TASMANIA PROVIDING ADEQUATE PROTECTION AS WELL AS CLARITY AND CERTAINTY FOR PRACTITIONERS AND FAMILIES?

> I will never surrender because of a broken system, I will fight for the survival of my child and I will continue to work on my own as it is better to be strong in the knowing that I am the only person that I can rely on – everything else leads to bitter disappointment and that is simply not an option for me.[185]

The Committee received a great deal of evidence in support of the rights of those with psychiatric disabilities and/or addictions and this has been discussed in Chapter 3. However, an alternative view was often expressed by family members and carers.

One mother explained the problems she faced in trying to support her daughter from the age of 12 and now at 18, and the lack of information to assist her to provide adequate protection-

> …I sit and wait, wait for her to be released with no calls, no explanation, no idea of what steps have been put in place. I am deliberately removed from all communication with a profession that has been put in place to assist my daughter and yet I am her primary care giver and without me life for her would possibly not continue. Why would the mental health system and the professionals that work within it think that handing her a few brochures on her options and sending her on her way be optimum treatment.[186]

She also discussed her frustration at not being able to get information regarding her daughter's health and wellbeing and treatment, even when she was a child. [187] As an adult, the problems continue-

> I cannot get any information, even to the point where last week she had surgery. I know that she has renal problems and liver function problems, but I cannot access any of that information and pass it on. As an 18-year-old, she is not mentally able to give that information.[188]
>
> It has been eye opening and gut wrenching. If ever a system was broken, this system is broken.[189]

Overall, the general lack of communication and advice for parents/ caregivers was of great concern.

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[185] Private Witness 3, *Written Submission*, p. 2.
[186] *Ibid.,* p. 1.
[187] Private Witness 3, *Transcript of Evidence*, p. 14.
[188] *Ibid*., p. 13.
[189] *Ibid*., p. 21.

> Parenting a child is challenging enough but parenting a child who suffers with mental illness is at times excruciating. Who provides assistance to these parents or care givers? Why aren't you using a resource that provides their service for free and often times will sit by their child for 24 hours to get them through a bad patch. Wouldn't you view working with caregivers as another option to achieve a successful outcome? Who is it that doesn't understand how good these young ones become at smiling, masking the pain, saying the right words?[190]

It is hard to believe that our legislative framework would allow such a situation to arise.

Parents and carers understand the privacy issues, but it is difficult to provide the best support possible without full information about diagnosis and treatment. A person with a mental disability is not always capable of making appropriate decisions about their own health and wellbeing-

> Yes, it's the patient's privacy. I understand that to a certain degree, if the person is fully capable of making decisions, but when people are not thinking straight, privacy doesn't work.[191]

Under the current mental health legislation practitioners are precluded from discussing such strategies with families.[192] Families can only be involved with the consent of an individual with capacity or when the individual is not able to provide informed consent.[193]

Ms Muskett explained the issues encountered by staff in this regard-

> Potentially the privacy act does say that a person has the ultimate right to decide what happens with their information. A lot of staff will say that is the letter of the law, and it is. A lot of staff. I mean, there are lateral and fairly innovative ways that you can move around that. Most people know that their family member has a mental illness so they themselves could provide a lot of their strategies and you can talk to people in general terms about how you might manage things…. The privacy legislation has made it difficult for a lot of people to know exactly where they stand and what they can do. The consumer-carer and family participation framework is clarifying some of that. Some of the policies that are coming out of that will tell staff what they can do without breaching privacy and mental health legislation at this point in time.[194]

It is interesting to note that the Mental Health Coalition's *Privacy Kit for Private Sector Mental Health Service Providers,* which was developed "… to give

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[190] Private Witness 3, *Written Submission*, pp. 1-2.
[191] Private Witness 2, *Transcript of Evidence*, p. 25.
[192] Muskett, *Transcript of Evidence, op. cit.,* p. 28.
[193] *Ibid.*
[194] *Ibid.*

practical assistance to providers in meeting their privacy obligations"[195], states-

> A health provider may … communicate mental health information to a responsible person (eg a partner, family member, carer, guardian or close friend), where it is necessary for the patient's appropriate care or treatment; or for compassionate reasons.[196]

Dr Rosenman also discussed the issue-

> Confidentiality is misused to keep people out, for various reasons. One is that if you involve the family it gets a whole lot more difficult; you have to deal with a lot more information. Practitioners worry, because of all that has been said, that they may end up in trouble for breaching confidentiality. My approach is to say that confidentiality probably limits what you can say to the family about this person's condition but does not limit what they can say to you and the information they need to get across to you for you to make a reasonable judgment. Then there is the argument about whether people are going to end up being over-influenced by the families and end up doing things because the families want it and not because the patient wants it.[197]

Dr Maharajh explained that the Tasmanian MHA did not include families although other countries included provisions for informing family members in their acts.[198] He believed that-

> The [Mental Health] act does not make a provision for inclusion of family members whereas in other countries, particularly where I come from, it is mandatory to have family informed the moment someone is put under the act… I think it is not always possible but there is room at least within 12-24 hours to include family. That is the first point. The second point is that we have been lacking in the degree to which families and consumers…or clients have been involved in the process of their assessment and treatment. … We are now making moves to see family as extremely valuable because we only see these individuals for a short time. Families live with them. So they are really the experts on what is happening and they shoulder the burden. That is worldwide. All literature on family input shows that they carry the burden of illness. We send clients home to their families. We only make provision for a small number of people. So that is an area that we need to be looking at and working on.[199]

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[195] Crompton, Mr Malcolm, Federal Privacy Commissioner, *Preface to the Privacy Kit for Mental Health Service Providers*, March 2004 accessed at http://www.pmha.com.au/files/Privacy%20Kit%20for%20Mental%20Health%20Providers.pdf .
[196] Mental Health Coalition, Privacy Kit for Private Sector Mental Health Service Providers, p. 7.
[197] Rosenman, Dr Stephen, *Transcript of Meeting*, 5 May 2009, pp. 11-12.
[198] Maharajh, *Transcript of Evidence, op. cit*., p. 27.
[199] *Ibid.*

Ms Muskett further clarified that changes are currently being considered-

> …embedding things like knowledge of the management plan and discussion with the family as part of a routine process and policy for inclusion. The difficulty is that under the current act family only legislatively can be involved to give substitute consent when the person is not able to give consent and people can be very, very ill and still able to give informed consent about their treatment. So it is a fairly narrow legislative framework that actually approves and condones the involvement of family in treatment decisions around a client. Whereas some clients are so ill and, while they can still make decisions about themselves, they would benefit very much from family inclusion.[200]

Not all witnesses agreed that information should be shared with families. Sometimes it was seen as more appropriate for an independent advocate to have the information and to assist the person with a psychiatric disability to make decisions about their treatment.

> With the greatest respect to families, while families have an important role in the care and support of their loved one who has a psychiatric disability and/or addiction, we must be careful when referring to their 'rights'. If a person has a psychiatric disability and/or addiction, is over the age of 18 and has mental capacity, the family has no more rights than any parent whose child is over the age of 18, has mental capacity and who may or may not have a disability.[201]

Obtaining the required medical care for people with a psychiatric disorder was a further area of concern. One witness told the Committee how difficult it was to ensure that his wife received attention by a psychiatrist and for continuity of carer-

> The other thing I wanted to point out was the continuity of care. You start with a psychiatrist here and he'd go and somebody else would come, and this would go on … That contact with the professionals, apart from myself, is probably the second most important thing to them.[202]

He advised that appointments would often be postponed or cancelled and that the effect on his wife was devastating.

> … All of a sudden she starts thinking that she's on her own and abandoned and that sort of thing. This is what starts to go through their heads.[203]

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[200] Muskett, *Transcript of Evidence, op. cit*., p. 27.
[201] Advocacy Tasmania Inc., *op. cit.,* p. 5.
[202] Private Witness 2, *Transcript of Evidence*, p. 31.
[203] *Ibid*.

Dr Ratcliff also identified the value and importance of continuity of care and carer for the long term health and wellbeing of those with mental illness. He stated-

> Whoever governs the decision as to whether they are admitted or not. Some people are so concerned about the potential suicide risk, that they will admit them every time, in crisis. But that works very much against their long-term management. The difficulty is that public mental health services have not generally been able to provide the degree of continuity in treatment that these people need. The problem is that they will get a new locum every six months in Launceston, a new registrar every three months and the management of these people involves very long-term involvement with one therapist. We need some means of getting appropriate therapists who are prepared to hang in there for a long time.[204]

It is evident that the circumstances in which orders to treat can be created lawfully for individuals are limited and sometimes unclear. Dr Pielage discussed the issue of when someone is brought in with a suspected mental illness, having attempted suicide, and explained that "[i]f they had obviously done something you might be able to stretch it and put them on an order to hold them."[205] He continued-

> The legislation is very vague sometimes. It is very difficult. If you put them on an order it does not necessarily allow you, in my understanding, to treat them [though this allows them to be detained]…you cannot treat them… People get very confused by it. I get very confused by it. The ones that are really difficult are those that the police bring in who are, say, drunk who say they want to commit suicide. That is a guaranteed ticket not to go in the cells.[206]

This issue relates back to the definition of mental illness. Dr Schneider explained that-

> …mental health workers find aspects of the current regime difficult particularly when people they can see are ill and unable to live their lives successfully do not end up being treated because definitions in the legislation are too rigorous. Families have particular difficulty understanding why somebody obviously ill and incapable of functioning as they used to would not warrant mandatory treatment.[207]

The availability of suitable accommodation was viewed as another area that was failing to protect those with a mental illness. According to one witness-

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[204] Ratcliff, *Transcript of Evidence, op. cit*., p. 35.
[205] Pielage, *Transcript of Evidence, op. cit*., p. 7.
[206] *Ibid.*
[207] Schneider, *Written Submission, op. cit.,* p. 5.

> … One of the key things that is missing from the equation is suitable accommodation because there is a huge gap between DPM in the Royal Hobart Hospital and even supported accommodation offered by the NGOs. Anglicare, Richmond Fellowship and others provide supported accommodation through packages from the government for people with mental illnesses. Mental Health Service reports such as Bridging the Gap and the like advocated support for those people with serious mental health illnesses. What has happened is that the NGOs are selecting people with milder, less traumatic mental illness, because there are so many to choose between. Why wouldn't we, if we were doing the same, do what they do? That leaves a group in Tasmania of perhaps 100 people, 100 people in the community who are least able to look after themselves, least able to care for themselves, most vulnerable and open to manipulation, to find a place of their own.[208]

He qualified his comments saying that-

> Tyenna provides a very good service. It was set up to look after those people from the Royal Derwent Hospital who were thought not to be suitable for settling into the community, but it has fewer than 30 beds. It services the whole State, it has a very good system of care. Each time our daughter has been admitted there it has been a very positive benefit for her but then discharge from there is too big a gap… there should be another wing, a refurbishment of the old Millbrook Rise to provide a step-down unit with the back-up of professional services on the same site.[209]

The Interim Report of the National Health and Hospitals Reform Commission, *A Healthier Future For All Australians,* also points out the importance of accommodation-

> Stable accommodation is particularly important for people with a mental illness, providing a secure environment for recovery and prevention. We propose that all state and territory governments provide people suffering from severe mental illness with stable housing that is linked to specialist support services. Associated with this, we propose that health professionals should take all reasonable steps in the interests of patient recovery and public safety to ensure that, when a person is discharged from a mental health service, it is clear where the person will reside, and someone appropriate at that location is informed.[210]

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[208] Private Witness 4, *Transcript of Evidence, op. cit*., p. 24.
[209] *Ibid*., p. 30.
[210] National Health and Hospitals Reform Commission, *A Healthier Future For All Australians*, Overview, accessed at http://www.health.gov.au/internet/nhhrc/publishing.nsf/Content/BA7D3EF4EC7A1F2BCA25755B001817EC/$File/A%20brief%20overview%20of%20the%20Interim%20Report.pdf, p. 17.

CONCLUSIONS

The Committee concludes that-

14. The current legislation does not provide adequate clarity and certainty to the medical profession to assist decision making.

15. It is important to provide continuity of care and carer for those with a mental illness.

16. The involvement and inclusion of family is important to the care and wellbeing of those with mental illnesses and should be facilitated when and where appropriate.

17. There is uncertainty regarding the operation of privacy laws related to access to relevant information concerning a person with a mental illness by carers and significant others, particularly in relation to the care of minors.

Chapter 5 - ADDITIONAL MATTERS

RESOURCES

> Tasmanians have a right to an adequately funded and resourced mental health system. People with a mental illness have a right to proper treatment and support. Staff have a right to have the resources to do the job properly in a safe and secure work environment. Work force shortages are negatively impacting on service delivery and quality outcomes for people with mental illness. Improving staffing in patient and community support care would mean better service for Tasmanians.[211]

It is evident that the services available in Tasmania for those with mental health disorders and their families differ depending on where in the state they live.

Evidence presented suggested that the north-west had recently appointed its first Clinical Director of Mental Health Services. [212] Dr Tudehope explained that as there are only two registrars on the north-west coast, they are not able to be continually rostered on and this means that other senior staff are often involved in the initial assessment of patients presenting in the DEM.[213]

Dr Tudehope described a quite inadequate acute mental health service in the north and north-west of the state-

> In the north-west - and this actually applies to the north also in many ways - in years past the public services were really run by a dedicated few who'd been there a long time. They were hard-working, very supportive units with reasonably good morale. Of course that started to fall down as they got to retirement age. Salaries were low; they had not caught up with mainland States. It is almost impossible to attract people and we had no area management unit of our own. We were run together with the north and north-west. Clinical directors did not exist so the doctors were employed in limbo, in a vacuum. They did not have any support.[214]

She went on to say that more recently the situation had improved-

> There has been a massive change in the last few years recognising those situations. After those long-term doctors left and retired we were existing with locums and people who were coming here really just to meet immigration requirements often. Once they were met they were off to the mainland where salaries were better. That really has changed...

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[211] Graham, Mr James, *Transcript of Evidence*, 13 February 2009, p. 1.
[212] Tudehope, Dr Judy, *Transcript of Evidence*, 23 March 2009, p. 2.
[213] *Ibid.*, p. 12
[214] *Ibid.*, p. 15.

> The salaries have now increased. They are commensurate with most mainland States. That has made a massive difference. People want to come. Opportunities for education and further training have improved. Launceston now has a very good registrar training program. We have dedicated area management units to get all the policies functioning correctly and dealing with complaints. We had no complaints system in the past. We had no system for analysing what was going wrong. All of these things have improved significantly over the last few years.[215]

She also advised the Committee that they had-

> …just introduced a CAT team, which is a crisis assessment team. That's going to take over a lot of the function of the on call and do a short-term follow-up of up to two weeks of patients who present to them; we hope to reduce admissions in this way because, through intensive care in the community; they can be visited every day or two if necessary. So they've had a psychotic break but are not considered to be requiring hospitalisation and they can be closely managed by that team.[216]

It is envisaged that this team will work late into the evening and will involve a group of five staff. [217] Dr Tudehope explained that it had been easier to attract staff due to an increase in the level of salaries available.[218] Overall, Dr Tudehope seemed impressed with the speed of reform in the area[219] and the fact that there is now a complaints system[220], however-

> …at a practical level - and in speaking with the DEM staff in the north-west … there is not a secure room in which to put these extremely agitated, disturbed or aggressive patients. An actual secure room would be very helpful. Getting a highly-resourced CAT crisis assessment team operating, which we are in the pathway of introducing, is important.[221]

The Committee was told that the Launceston General Hospital experiences problems with caring for people who have attempted to commit suicide between the time they present to hospital and when their mental health can be adequately assessed.

Dr Pielage explained that-

> Ideally they should be in some sort of a cell or something where they cannot do any harm to themselves but to do that they need to be supervised. I suspect the police do not have the resources.

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[215] Tudehope, *op.cit*. p. 15.
[216] *Ibid.,* p. 12.
[217] *Ibid.*
[218] *Ibid.,* p. 15.
[219] *Ibid.*
[220] *Ibid.*
[221] *Ibid.,* p. 20.

> Quite frankly we do not really have the resources either because some of these people are quite aggressive and violent.[222]

Evidence suggested that there were specific rooms available for such situations at the Royal Hobart Hospital. Dr Pielage continued that-

> The Royal has a few things we do not have. We lack security staff. Our mental health service does a good job with very limited resources but we certainly do not have a mental health nurse in the department 24 hours a day. [223]

He also stated-

> The mental health services in the north have for many years been deficient. There is a deficiency of psychiatrists within the hospital system and outside the hospital system. There has always been a long-term general shortage of psychiatry registrars in the hospital system so we function very differently from the Royal Hobart Hospital in that there is a community mental health team which was originally set up to service patients in the community but which has taken on the role of first call for patients in the emergency department largely, historically, due to a lack of psychiatry registrars.[224]

Dr Pielage believes that the under-resourcing of departments has often been due to difficulty with recruiting, not necessarily a lack of available funds.[225] Evidence provided suggests that the problem of attracting staff has been resolved of late and that greater choice is now available in making staff selections.[226]

However Dr Pielage made the observation that-

> Sometimes we do things because we do not have other resources available. For example, the police bring patients to us because they do not have resources available. We keep them in the ED or they get admitted because there are not other resources available. That happens all the time. We have to deal with problems with the resources that we have.[227]

Dr Milford McArthur, Clinical Director, Department of Psychological Medicine, Royal Hobart Hospital, explained that the North West Regional Hospital, Launceston General Hospital and the Royal Hobart Hospital all have high dependency units attached to them (these were described as similar to psychiatric intensive care departments).[228] Dr McArthur did however tell the

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[222] Pielage, *op. cit.,* p. 7.
[223] *Ibid.,* p. 8.
[224] *Ibid.,* p. 4.
[225] *Ibid.*, p. 13.
[226] Maharajh, *op. cit.,* p. 14.
[227] Pielage, *op. cit.,* p. 26.
[228] McArthur, Dr Milford, *Transcript of Evidence*, 19 March 2009, p. 37.

Committee that over the last year the number of registrars had reduced by four as at March 2009 no replacements had been appointed.[229]

Dr Tony Lawler, Director of Emergency Medicine, Royal Hobart Hospital, pointed out that-

> One of the initiatives that we have adopted over the last six months is that we have appointed a registered psychiatric nurse who is present in evening shifts because that is the time in which we have the gross preponderance of mental health presentations. They not only provide one-to-one nursing care with those individuals but also, obviously, they develop their own skill base to provide some education and training for the rest of the department. So even within the emergency department, which is, by necessity, a generalist service, we have an area within the department that has, for a significant proportion of the week, specialist psychiatric nursing exposure. It is a fantastic addition.[230]

Dr Lawler described how patients were treated in emergency after their initial assessment-

> They receive full nursing supervision. They are watched as any other patient in the emergency department is. They are kept either in what we call the seclusion rooms, which are our mental health assessment rooms, or one of the consequences of bringing our psychiatric nurse online is that we have also cleared out the three cubicles next door which can serve as an overflow cubicle, because we have a significant proportion of patients who come in with, for instance, suicidality and have taken an overdose of medications that renders them unassessable and we treat them as medical patients. So they might come in at 8 p.m. having taken an overdose of Valium, for instance, and we will keep them in the department until the morning, because calling Mental Health Services or calling inpatient psychiatry services is really a waste of time because they cannot make any decision to detain or release until then, and we have those three cubicles that can then to a certain extent act as a psychiatry overflow area or mental health area overflow.[231]

Dr McArthur acknowledged that the RHH did take patients from other areas at times because they "… tend to be better staffed and we offer further opinions, if that is required from treating teams…"[232]

Mr Christopher Fox, Southern Area Manager for the Psychiatric Intensive Care Unit, told the Committee that in the south there is an after hours intervention team available until 11pm, 7 days a week.[233] This service-

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[229] McArthur*, op. cit.,* p. 46.
[230] Lawler, Dr Tony, *Transcript of Evidence*, 19 March 2009, p. 44.
[231] *Ibid*., p. 47.
[232] McArthur, *op. cit.,* p. 37.

> …consists of clinicians who are based in the community. In Hobart the intervention team comprises two clinicians who are based at the Peacock Centre, which is in North Hobart, one clinician who is based a Gavitt House in Glenorchy and one clinician who is based at Bellerive Quay. When contact is made, and frequently those contacts come through from the help line, the clinicians respond to that contact based on assessed needs.[234]

In addition-

> Mental Health Services does have a 24-hour service that is available for mental health emergencies - that is the mental health help line, which is manned 24 hours a day, seven days a week. Whoever contacts it - and it is quite often the police - gets a clinician on the other end of the line who would provide advice in a scenario such as that. At this point in the south we do not have the capacity after 11 p.m. to provide an on-ground response. The data we have of presentations after 11 p.m. until 7 a.m., from a strict financial or budgetary perspective would indicate that the cost of having staff in place for what may very infrequent presentations or scenarios would potentially outweigh the benefit in having that service there.[235]

Resourcing issues have also led to the closure of the Peacock Centre. One witness discussed how valuable the mobile intensive support team (MIST) at the Centre had been to his family-

> …MIST was a great help to us and our daughter…There were a number of times where we could ring the Peacock Centre and one of the MIST team would come around. They were a welcome and familiar face for our daughter and for us. Usually it was connected with not taking medication. That lack of professional support has, I think, had a big impact on former clients of Peacock Centre. The feedback that I get from former clients of Peacock Centre I've come to know because our daughter was there is that a few are comfortable, most are not as well as they used to be, a number are admitted more often to the Royal because they do not have the kind of support that they used to have. It is one other area, in terms of legislation, that is a consequence of outsourcing.[236]

He was concerned that appropriate arrangements had not been made for the "integration of services"[237] following the closure.

Mr Fox explained why the changes had occurred-

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[233] Fox, Mr Christopher, *Transcript of Evidence*, 19 March 2009, p. 17.
[234] *Ibid*., p. 17.
[235] *Ibid*., p. 20.
[236] Private Witness 4, *Transcript of Evidence, op. cit*., p. 25.
[237] *Ibid.,* p. 26.

> The rehabilitation team and the mobile intensive support team used to both sit at Peacock, one on each floor. The major problem we found with that system was that there was a whole number of silos…What we found was that a whole number of clients were in suspended animation, for the want of a better word. They were discharged from one team - or they no longer met the model of care or the resourcing requirements of one team - but they could not get into or they hadn't been picked up by the other team. So the decision was made…to put in place a population-based model where basically if you live on the eastern shore you are the sole responsibility of the Clarence and Eastern Districts Adult Community Mental Health Service seven days a week, 16 or 17 hours a day. If you need rehab, that team manager is your rehab; if you need crisis support, that team manager is your crisis support.[238]

He told the Committee that there had been positive feedback about the changes.[239] Whilst Mr Fox admitted that the Peacock Centre had previously offered some extra activities, he explained that these had been outsourced to an experienced private provider and that favourable comments had been received about the offerings of the new services.[240]

When discussing the matter of people with borderline personality disorders, Dr Maharajh suggested the use of dialectical behaviour therapy which would require appropriate resourcing, stating-

> Research has shown that coercive treatment does not work and that using the Mental Health Act is usually in the longer term not productive. Short-term use to contain risks is useful but in the longer term it does not allow the person to take responsibility for themselves. That's what dialectical behaviour therapy does; it allows them to examine their thinking; it allows them to change their thinking, get into new patterns of thinking and develop new skills to deal with dialectical ways of coping with life because of the lack of skills and the problems they have had.[241]

Dr Maharajh further stated-

> We simply don't have the services to cater for them. In an ideal world most of these clients would be sent to an outpatient department, dialectical behaviour therapy would be given, they would have multiple support which all amounts to resources and availability of trained staff … Research has shown that dialectical behaviour therapy does work and it does work effectively but it is,

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[238] Fox, *op. cit.,* p. 32.
[239] *Ibid.*
[240] *Ibid.,* pp. 32-33.
[241] Maharajh, *Transcript of Evidence, op. cit*., p. 25.

> as I said, costly to train people, costly to run and very resource intensive.[242]

Dr Jenny Tudehope, Clinical Director, Mental Health Services North West, supported this view-

> As Dr Maharajh says, we know the appropriate and best treatment for people with borderline personality disorders. One particular type is a combination of what we call dialectical behaviour therapy and individual therapy. Ideally it occurs often several hours a day, every day of the week …it's a day program and it's very intensive; it requires two or three therapists and a group of maybe eight patients. It may go on for eighteen months or two years sometimes and to date we haven't had the resources to do that. It would be wonderful to be able to do so as various staff are trained in it.[243]

Professor Malpas stated-

> In Tasmania, dialectical behaviour therapy does seem to work, but it needs support. It needs to be there over a long period and there is no such program in Tasmania. The one program that came close was only available to young girls.[244]

The Chair of the Committee received further support for this treatment when she met with Dr Rajiv Singh, the Clinical Director at the Waikato District Health Board, Hamilton and discussed the use of dialectical behaviour therapy in New Zealand**.** Dialectical behaviour therapy is provided to persons with borderline personality disorders with a reported high degree of success. Staff who provide the therapy are specially trained and work with a specific caseload of people with this disorder. As it is a quite intensive therapy, often lasting over many months, it needs to be adequately resourced and funded to ensure positive outcomes can be achieved.

Commenting on the services currently available, Dr Schneider explained to the Committee that-

> I think it is fair to say that there is no intensive rehabilitation anywhere in the State now except at the Wilfred Lopes centre. I think the service has probably recognised that gap but I don't think they have the resources to do anything about it at the moment. We are ending up having silly arguments with the mental health tribunals about keeping people who really could move on. It has been accepted that they will stay in our highly restrictive service because they are not going to get rehabilitation anywhere else. They might get a bit of care but not training them to make their budget, to do their cooking and cleaning, or taking them to the

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[242] Maharajh, *Transcript of Evidence, op. cit*., p. 24.
[243] Tudehope, *Transcript of Evidence, op. cit*., p. 24.
[244] Malpas, *Transcript of Evidence, op. cit.,* p. 15.

> supermarket so they are not overwhelmed when they are suddenly faced with the real world again.[245]

CHILDREN AND ADOLESCENTS

The lack of services provided for children and adolescents was also an issue of concern to the Committee.

A witness with personal experience of youth mental health requirements suggested that-

> There are the two age groups that we have to distinctly keep in mind. A quick-fix for the older ones would definitely be a place detached from A&E where they could get their own rescue. I know there are houses in town that you can let kids - the adults can ring up but there are very few and only within working hours and most of these kids experience it after hours.
>
> With the younger ones, it is definitely relationships with the schools and the links that go back to the families and care givers. Schools working with agencies like Oakrise basically do not exist. They work too independently to be united in a treatment that they give, and definitely with the carers. The amount of time and the resource that is saved by using carers, such as myself, is phenomenal but it is not tapped because we don't know what we're doing, haven't got a clue.[246]

Dr Crawshaw told the Committee that-

> We are reviewing the services that we provide to young people and whether there is capacity within current resources to provide an improved service for young people who have in-patient needs. There are problems due to the small size of the State. If you use international figures, Tasmania's population would probably be predicted to need at most seven or eight in-patient beds for mental illness. I am sure you appreciate this.

He then continued-

> We have been trying incrementally to improve the services in terms of the Ashley situation. I currently fund a visiting adolescent forensic psychiatrist who provides 10 to 12 days a year of consultation, secondary consultation and support for youth justice, which is an improvement over what it used to be. I used to extend myself to trying to do that.[247]

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[245] Schneider, *Transcript of Evidence, op. cit.,* p. 4.
[246] Private Witness 3, *Transcript of Evidence*, p. 19.
[247] Crawshaw, *Transcript of Evidence*, 12 February 2009, *op. cit.,* p. 98.

In relation to Child and Adolescent Mental Health Services, Dr Tudehope commented on the level of service provision-

> …there is no child and adolescent inpatient psychiatric bed in Tasmania and in the south they've just managed to get a small service going but no dedicated beds but at least it's better than it was. So if we have to admit an under 18-year-old we'd have them specialled at vast cost and kept separately from the often very disturbed adults there. It still can be a trauma to them actually being hospitalised. Even if they are very ill themselves with acute schizophrenia or whatever it is, the experience of hospitalisation can still be traumatic to them. There is a proposed eight-bed adolescent unit in Hobart, and I strongly endorse that.[248]

The reason that changes need to be implemented is explained by the fact that-

> Mental health problems in childhood and adolescence can have far reaching effects on the physical well-being, educational, psychological and social development of individuals. Children who are mentally healthy are better able to-
> - learn;
> - experience stronger relationships with teachers, family members and peers;
> - negotiate challenges including the transition into adolescence and then adulthood;
> - achieve long-term education and career goals; and
> - enjoy a better quality of life.
>
> When early signs of difficulty are not addressed, mental health problems can potentially become more serious and possibly extend into mental disorders.[249]

The Committee received many personal recollections and stories from the families of those who suffer from mental health concerns. One key area in need of attention is early intervention for those who are diagnosed with genetic conditions which cause intellectual disability.

Fragile X is a condition which causes intellectual disability.[250] Some evidence received by the Committee suggested that it was imperative that early intervention services were increased for children who were found to have such conditions as it could greatly effect their quality of life.

In an effort to address symptoms early, the American Academy of Pediatrics has a policy that-

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[248] Tudehope, *Transcript of Evidence, op. cit*., p. 30.
[249] Commonwealth of Australia, *New Early Intervention Services for Parents, Children and Young People* accessed at http://www.mentalhealth.gov.au/internet/mentalhealth/publishing.nsf/Content/early-intervention-1
[250] The Fragile X Association of Australia, http://www.frgilex.org.au

> …recommends that developmental surveillance be incorporated at every well-child preventive care visit, and that any concerns that are raised be promptly addressed with standardized developmental screening.[251]

A 2001 article on the mental health of young Australians suggested that-

> Mental disorders impose a heavy burden on children, families and communities and often persist into adulthood. The cost to society in human and economic terms is great. There is broad agreement that we need to detect these problems early, provide effective treatment and attempt prevention.[252]

This article suggests that four things need to occur-

> …increased awareness that mental health problems are a major issue in child health and try to prevent them…Improve the use of resources and access to services…Increase funding for mental health services for young people…Increase the number of specialists in mental health and carry out more research.[253]

In response to the perceived need for greater focus on children and young people, the *KidsMatter* campaign has been developed and is to be rolled out nationally in 2010.[254]

In explaining the basis and motivation for this campaign its website states that-

> The school structure offers a systematic means to identify children at highest risk or who are already showing 'early warning signs', intervene early and engage children and young people to effective mental health treatment so that they are less likely to suffer from severe and enduring difficulties. Schools are also uniquely placed to provide information and support to parents and families regarding their child's mental health and wellbeing.[255]

It also says that-

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[251] Lipkin, Dr Paul, "Special Needs: Realizing Potential, Moving Forward in Developmental Screening", *Pediatric News*, September 2006, p. 34.

[252] Editorial, "The mental health of young Australians: Are we as a nation taking seriously enough the task of preventing and treating mental illness in the young?" *MJA* 2001; 174: 380 citing Report of the Surgeon General's Conference on Children's Mental Health: a national action agenda. Washington, DC: US Public Health Service, 2000; Australian Bureau of Statistics. *Mental health and wellbeing profile of adults*, Australia 1997. Canberra: AGPS, 1998; Raphael B. *Promoting the mental health and wellbeing of children and young people. Discussion paper: key principles and directions*. Canberra, AGPS, 2000.

[253] Editorial, *op. cit*., p. 380.

[254] Commonwealth of Australia, *op. cit.*

[255] *Ibid.*

> The measure recognises that an estimated 14-20% of children and adolescents are affected by a mental health problem every year, but only one in four receives any professional help.[256]

INTERSTATE RECOGNITION

In order to ensure that Tasmanian treatment orders are adequately enforced in the best interests of those with a psychiatric disorder, it seems that legislative intervention or guidance between states could be a useful reform.

One witness, who had some personal experiences with the jurisdictional boundaries of orders, said that-

> Interstate, the order is not enforceable, but the patient typically has no medication; health declines, behavioural incidents attract police attention, and if fortunate is detected as needing medical treatment. If the incident is complicated by alcohol or street drugs and/or stressed police then the behaviour is linked to effects of drugs or alcohol and the patient retreats into another world or behaves in a bizarre way.[257]

Medical professionals, such as Dr Schneider, had similar concerns-

> There has been talk for years about interstate agreements. I would have thought this is actually being worked on but I don't know; it should have been. Yes, people can cross the State's border and they're free of most of the legislative restrictions like the community treatment order, for example; all they have to do is jump on the boat. There's nothing to stop them doing that. I think that's unfortunate and there needs to be inter-jurisdiction agreement that orders remain valid across the country.[258]

Overall, the witness expressed his frustration that-

> Australia has nation-wide recognition of state drivers' licences, organ donor identification and educational qualifications, to name but a few. Why are CTOs not yet recognised nationally when they assist those people with mental illness to receive medication and care that are essential to their health and well-being. Poor coordination between state health systems also contributes to overload of police, emergency services and hospital acute care in each state.[259]

Dr Crawshaw stated that-

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[256] Commonwealth of Australia, *op. cit.*
[257] Private Witness 4, *Written Submission*, p. 2.
[258] Schneider, *Transcript of Evidence, op. cit.,* p. 7.
[259] Private Witness 4, *Written Submission*, p. 2.

> The current Mental Health Act has the capacity for those orders to be transferred. We have to reach interstate agreements around that and that will be the next piece of work we will do once our legislation is passed. The intention is to transfer orders. It is problematic because of the way different States craft it. [260]

His evidence suggested that this was an area being discussed nationally. [261]

ROLE OF POLICE

Police have a challenging role in providing care and support to people with mental illness that has been exacerbated by deinstitutionalisation. Historically police have not received an appropriate level of training in order to recognise mental illness. This has resulted in police sometimes acting in a manner that has led to complaints.

Professor Malpas told the Committee that he is involved in the ethics training of police recruits at the Academy and commented that he was pleased to see that now "there is a real sense that compassion is a part of their jobs as police officers, a sense of real ethical commitment and values."[262] He believes that the focus on training has been influential in lowering the rate of complaints against police officers. [263]

It was also acknowledged by some witnesses that the roles and requirements for police were not clear under the current system. Dr Crawshaw explained that one of the goals of the legislative review is to try-

> … to be much clearer about what happens when someone is taken into protective custody and what happens in terms of the handover process with respect to protective custody. There will always be times when, because of the risk associated, the police or the ambulance service may well need to assist our clinicians. There may well be times when we can facilitate more of a health response rather than a police response. It really has to depend upon that risk and working with the police. One of the things which we are trying to be clearer on…is to be clear about what happens when, say, the police bring them into the hospital and they allow for the capacity to be handed over clinically, without the police necessarily having to wait.[264]

This was also an area of concern to police. Inspector Mewis commented that-

> We would like to see the legislation reflect the fact that once we present them to the primary admission centre for assessment, the health authorities then take responsibility. The Northern Territory and the ACT both have legislation that quite clearly states that the

[260] Crawshaw, *Transcript of Evidence*, 12 February 2009, *op. cit.,* p. 93.
[261] *Ibid.*
[262] Malpas, *Transcript of Evidence, op. cit*., p. 19.
[263] *Ibid.*
[264] Crawshaw, *Transcript of Evidence,* 19 March 2009*, op. cit*., p. 18.

> primary admission centre will take responsibility for custody of the person once they are presented. At the moment that is not the case here; our people will sit there for anything up to four-hours until that person is assessed.[265]

Dr Crawshaw understood that-

> …the current legislation makes it difficult for all involved. I fully understand the frustration of the police at having to sit around for four hours. They are some of the elements that we are trying to address in the re-draft currently with the Parliamentary Counsel. We are clearly looking at the capacity for the police to hand over the custody within the hospital setting so that we continue to provide a health intervention. We are looking at assessment orders which would allow us…to have people who continue to require observation and so forth, not necessarily simply in hospital but also that they may need to be followed up within the community and to have a graduated response.[266]

Inspector Mewis believes that-

> Realistically, the police should only intervene when it really becomes a matter of public safety or safety to the individual. Beyond that we really shouldn't be involved. The general principles of human rights state that police are a last resort in intervening with people suffering mental illness, for a whole range of reasons. Our preference would be that that was the case on all occasions.[267]

On the level of training provided to officers regarding issues around mental illness, the Inspector continued-

> Our recruits are given some training but it is more about identifying a person suffering from mental illness, the key indicators and obviously in the legislation and their powers and how to deal with it. Mental Health Services have, in the past, provided some training out in the field. We had what are called district training days once a week in each of the areas which combine a whole range of training and from time to time mental health have provided us with some training on those days for our infield police. That does not happen that often.
>
> I think, largely, our people do a very good job, given the circumstances that they face, particularly at all hours of the day and night, and the fact that they are not trained specifically to make diagnoses.[268]

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[265] Mewis, *Transcript of Evidence, op. cit*., pp. 2-3.
[266] Crawshaw, *Transcript of Evidence*, 19 March 2009, *op. cit.,* p. 28.
[267] Mewis, *Transcript of Evidence, op. cit.,* p. 5.
[268] *Ibid.,* p. 6.

Dr Maharajh suggested that the model used in New Zealand, which provides a secure and safe cell for those who are intoxicated to be held and closely observed, with access to a dedicated mental health nurse and police general practitioner, was a model that could be considered in Tasmanian major centres.

> New Zealand police have a safe room on the monitors that is observable from the front desk so that if somebody who is really drunk cannot be assessed they are put in the room and observed. The room is specially built for that purpose. It works extremely well. At any point when they do sober up, no matter what time it is, the call is made for an assessment. I think it really works well.
> …If it is within the hours of the crisis team, which is before 11 o'clock, the crisis team goes out to them. If it is after then the police bring them in.[269]

Dr Maharajh further stated-

> Because of the unpredictability of the intoxicated patient, they may have hit their head and be suffering from a neurological injury. A general practitioner is always called in to do a physical...There is a GP affiliated to that police station who would be on call. He or she would authorise arrangements, come in and do a physical and make sure that we are not seeing pre-coma instead of drunkenness, which brings in the safety factor.[270]

He also informed the Committee that New Zealand police officers receive mental health training which occurs four times per annum updating officers in the area of general mental health conditions.[271]

CONCLUSIONS

The Committee concludes that-

18. There is not an equal provision of mental health services across the state.

19. Different hospitals have varied and inconsistent support for persons with a mental illness presenting to the Department of Emergency Medicine.

20. Dialectical behaviour therapy provides an effective treatment for persons suffering from borderline personality disorders in other jurisdictions but is not available in Tasmania.

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[269] Maharajh, *Transcript of Evidence, op. cit., pp*. 22-23.
[270] *Ibid.,* p. 23.
[271] *Ibid*.

21. There is a lack of resources/services, particularly in-patient mental health services for children and adolescents. A visiting service of 10-12 days a year at Ashley is inadequate.

22. There is a need for interstate recognition of treatment orders.

23. There have been occasions where persons with serious mental health illness have received the most appropriate and effective care only after they have committed a crime and been treated as a forensic patient at the Wilfred Lopes Centre.

24. Early intervention in specific mental illness and conditions, such as Fragile X Syndrome, result in improved outcomes.

25. Evidence supports the benefit of and need for early intervention and treatment in serious mental health disorders.

26. Current training practices have resulted in police gaining a better understanding of people with a mental illness, which has led to fewer complaints against police.

27. Police time and resources are consumed disproportionately when dealing with persons with mental illness that require medical assessment.

Chapter 6 – FUTURE DIRECTIONS

Independent advocate, Ms Dannii Lane summarised her views on the problems in the legislation in providing adequate protection and support to individuals with mental illness by saying-

> It is a matter of trying to find a balance between the clinical needs of the client and the clinician and the humanitarian rights of the patient, and all this has to work within the legal framework of an act that is essentially obsolete and ambiguous, to say the least, which is a very difficult task and I do not know that there is any easy answer to it other than scrapping the act entirely.[272]

Ms Smith and Ms Rigby's written submission alludes to a similar idea-

> What is clear is that if there were only guardianship legislation, it would be possible to treat people with mental illnesses effectively and efficiently under either a guardianship appointment or by means of a determination of consent from the Board. In addition, because guardianship laws require a finding of incapacity, there is no prospect for involuntary treatment of a person who has capacity and refuses treatment. Therefore the guardianship legislation eliminates one of the most noxious of the discriminatory elements of mental health legislation.[273]

Dr Rosenman wrote in 1994 that-

> …separate mental health laws should not exist in a modern liberal state. They are gateway laws which maintain the walls around psychiatric care and treatment. The benevolent and paternal needs that they satisfy are better handled in a non-discriminatory manner under modern guardianship law, which separates medical advice from consent and maintains the guardian's observation throughout treatment.[274]

Mr Abel stated in his written submission that what was needed was-

> … a unified legislative approach to issues of substitute or assisted decision-making based on determinations of incapacity. This latter approach is squarely founded in international human rights-based developments over the past two or more decades, particularly in British and other European jurisdictions… they reflect the over-arching influences of the European Convention on Human Rights (ECHR) and the European Court of Human Rights (ECtHR) over now some six decades. These in turn reflect wider international conventions, charters and principles, most recently the 2006 UN

[272] Lane, Ms Dannii, *Transcript of Evidence*, 12 February 2009, p. 59.
[273] GABMHT, *op. cit.,* p. 50.
[274] Rosenman, Stephen, "Mental health law: an idea whose time has passed." *Australian and New Zealand Journal of Psychiatry* (1994) 28: 560-565, p. 565.

> Convention on the Rights of the Disabled, ratified by Australia in July this year [2008] (the 2006 Convention).[275]

TasCOSS also supported the investigation into the merging of governing bodies and legislative framework that is capacity based. The written submission stated-

> TasCOSS support the proposal that new capacity-based legislation be considered that applies to a range of situations in which a person's capacity to consent and to make decisions for themselves is likely to be an issue.[276]

The Tasmanian Government in their written submission also stated that-

> Several international jurisdictions including the United Kingdom, Scotland and Canada have implemented generic capacity legislation. The development of similar legislation could be explored to determine its applicability to Tasmania's circumstances… Generic capacity legislation has the potential to provide a framework for the provision of treatment for the range of persons with a decision-making disability. This would include the majority for whom mental health treatment is required and those whose disability has been brought about by way of a drug or alcohol addiction. Importantly, a capacity based framework would provide a non-discriminatory approach insofar as the framework would apply to persons on the basis of their capacity or lack thereof, rather than on the cause of their incapacity, and would be reflective of the standards that apply in relation to 'mainstream' medical treatments. That is, disability would be acknowledged insofar as it is relevant to decision-making, but would otherwise be left outside of the equation. [277]

It is evident that there is support from various sections of the community for a change to the way legislative intervention is structured for mental health issues. Throughout the Committee's inquiry there was the repeated suggestion that generic capacity-based legislation should be created to ensure that all those lacking capacity are catered for via the one means and without the concern of discrimination or repetition.

Mr John Lesser, President of the Mental Health Review Board of Victoria, explained that-

> Personally, I think having generic capacity legislation is a good move in the sense that you equalise the field for everyone. There is an argument about whether mental health acts should exist at all and whether you just deal with everyone on a capacity basis. I

[275] Abel, *Written Submission, op. cit*., p. 3.
[276] TasCoss, *Written Submission, op. cit*., p. 2.
[277] Tasmanian Government, *Written Submission, op. cit*., p. 29.

> think there is an argument to say you can do that but it tends to not be something that society has handled very well.[278]

An article by Professor Dawson argued that incapacity legislation-

> ... can focus on the particular abilities a person must demonstrate (such as understanding and foreseeing the consequences of treatment) for others to accept the validity of the person's decisions. Where these abilities are lacking, the person may be considered incapacitated regardless of cause.[279]

The presidents of the Guardianship and Administration Board and the Mental Health Tribunal put forward a comprehensive submission in relation to such a scheme which would provide "…a new protective regime that is capable of considering all of the protective needs of a person with a decision-making incapacity within one forum."[280]

They explained that their proposed new system would take-

> …the best of the guardianship system and applies it to people with all disabilities that affect their decision making. Instead of making 'treatment' and 'detention' decisions for people with mental illnesses, the new incapacity system will make 'health care' and 'hospitalisation' decisions via a new system of agency.[281],

And that-

> At its best, guardianship is a legally recognized one-to-one relationship, a system of personal agency which can be respectful, enforceable, intimate, customized and flexible.[282]
>
> It is the capacity for the substitute decision maker to take into account wider environmental factors that will be of greatest benefit to the represented person. Decisions about hospitalisation and treatment considered in isolation from practical issues such as whether the represented person's rent is being paid, care arrangements for their children or pets, alterations to pension status etc, can materially inhibit a person's rehabilitation from acute illness.[283]

They recommend that-

> …the extent of representation ought to reflect the deficits in decision making and the need for decisions to be made for each individual.[284]

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[278] Lesser, *Transcript of Meeting, op. cit*., p. 14.
[279] Dawson and Szmukler, *op. cit*, p. 505.
[280] GABMHT, *op. cit.,* p. 29.
[281] *Ibid.,* p. 32.
[282] *Ibid.,* p. 36.
[283] *Ibid.,* p. 37.
[284] *Ibid*., pp. 37-38.

A further recommendation in this paper is that the offices of Public Guardians and Public Advocates are vital for the protection of rights and awareness of issues.[285]

Ms Muskett, and others, were concerned about this idea. She said-

> I think that there may be some fundamental problems with doing that if we are just looking at the generalised capacity to consent…some of the sickest people that were coming in were very depressed; they had made decisions about taking their own lives against the background of the death of a spouse or something else; they still retained their capacity to make an informed consent about those decisions but we didn't want to treat them because you would know full well that that was probably the outcome if you didn't actually treat the underlying depression.
>
> So if you just have a generalised order that specifically looks at capacity then we are going to miss giving treatment to some of those clients that would probably benefit from it and desperately need it because it's not about capacity.[286]

According to Dr McArthur-

> It probably does not matter to us how many acts there are. The problem for us is the implementation of them. If we have to have two hearings in a short period of time for one patient it is very distressing for the patient. They find the hearings quite onerous. They usually take at least an hour and occasionally quite a lot more. So if we could deal with permission or authority to detain a patient and treat a patient with one hearing that would be of benefit, I am sure, to the patients rather than having to subject them to two.[287]

Obviously there are some issues that require further investigation. However, the Government submission suggested that-

> Generic capacity legislation could regulate capacity issues across the range of disability sectors by codifying the common law presumption in favour of a person's decision-making capacity and setting out the factors that determine decision-making capacity, including the person's ability to believe, understand and retain information and to make and communicate decisions. The United Kingdom generic capacity legislation also recognizes advance decisions and lasting powers of attorney.[288]

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[285] GABMHT, *op. cit.*, p. 38.
[286] Muskett, *Transcript of Evidence, op. cit*., p. 29.
[287] McArthur, *Transcript of Evidence, op. cit*., p. 38.
[288] Tasmanian Government, *op. cit.,* p. 29.

Mr Abel discussed the fact that British systems had for some time been far more highly scrutinised than those in Australia.[289] He commented that-

> What is occurring in the UK is a convergence, an articulation of laws increasingly around issues of incapacity rather than the historical distinction of mental health from other disabilities. Each of the British reviews that I am talking about – the Bamford review in particular and the Millan review in Scotland – has resulted in the strengthening of these oversight bodies that I am talking about and widening them out. At the same time in parallel, legislation internationally is being articulated around this notion of incapacity.[290]

He thought that the important achievement of such reforms was that-

> …we are increasingly seeing oversight commissions regarding issues of disability or all issues related to mental disorder. Be that a profound, a severe or a moderate intellectual disability or a mental illness per se, these bodies are now being charged with an oversight role of all activities, all services which occur around these people.[291]

Guidance can indeed be sought from some progressive studies overseas. The Bamford Committee report has recently suggested that such a fused system be adopted in that jurisdiction.[292]

In addition, the provision of adequate resources is likely to continue to be a problem for those involved in mental health services. The Committee is concerned that people may attempt to stay on orders for longer than necessary just to ensure that they receive some support. It may be that more needs to be done for those not receiving treatment in hospitals.

Defining a mental illness is one of the most complex issues within the legislation and currently the Act only covers those defined. This means that there will always be a group of people who do not fall within the provisions, but ostensibly require some assistance. How this can be rectified is unclear, though guidance from other jurisdictions could prove useful.

In order to ensure that the rights of those with mental illness are protected, as much as possible, and guarantee fairness in the system, regular review of orders is necessary. Contradictory evidence was provided about the exact time frames desirable, but all parties agreed that set reviews are necessary and it is thought that Tasmania already does quite well in this regard.

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[289] Abel, *Transcript of Evidence, op. cit*., p. 45.
[290] *Ibid.,* pp. 45-6.
[291] *Ibid.*
[292] Dawson, *Written Submission, op. cit*., p. 1.

Appendix 1 - Bamford Committee (Northern Ireland) Overarching Recommendations

1. There should be a single, comprehensive legislative framework for the reform of Mental Health legislation and for the introduction of Capacity legislation in Northern Ireland. This should be through the introduction of provisions for all persons who require substitute decision-making. A framework is proposed for interventions in all aspects of the needs of persons who require substitute decision-making, including mental health, physical health, welfare or financial needs.

2. The framework should be based on agreed principles, explicitly stated in legislation and supplemented, if necessary, in supporting Codes of Practice.

3. The principles underpinning new legislation should support the dignity of the person and have regard to-

Autonomy: respecting the person's capacity to decide and act on his own and his right not to be subject to restraint by others.

- There should be an assumption of capacity and provision of care and treatment should be on a partnership and consensual basis, as far as possible. Respect for capacious decisions should extend to those decisions made legally in advance and where the person grants specific decision-making powers to another on his behalf, for the time when he loses capacity himself.

- Participation – users of services should be fully involved to the extent permitted by the person's capacity, in all aspects of their care, support or treatment. Users of services should be provided with all the information and support necessary to enable them to participate. This may include the involvement of advocates and/or carers. Account should be taken of past and present wishes in so far as these may be ascertained.

Justice: applying the law fairly and equally.

- Non-discrimination – persons with a mental disorder or a learning disability should retain the same rights and entitlements as other members of society.

- Equality and respect for diversity – persons should receive treatment, care and support in a way that accords respect for, and is sensitive to their individual abilities, qualities and cultural backgrounds. The legislation should not discriminate on

grounds of age, gender, sexual orientation, ethnic group, disability, social class, culture or religion.

- Reciprocity – the loss of a person's rights by detention or by compulsion to treatment and care should be matched by an obligation to provide adequate treatment and care for that person.

- Partnership – services should develop effective partnerships to ensure continuity of care across age and service boundaries.

- Fairness and transparency – there should be fairness and transparency in decision-making, and the right to representation for challenge of due process. Proceedings should be timely.

- The specific rights of children, including the right to education, should be protected.

Benefit: promoting the health, welfare and safety of the person, while having regard to the safety of others.

- Where interference is necessary and permissible, the best interests of the person should be protected and promoted, including protection from abuse and exploitation.

- Intervention should only be undertaken using the legislation to achieve benefits which cannot be achieved otherwise. Benefit to the person should include, but not be limited to, reduction of risk of harm to self or others.

Least harm: acting in a way that minimises the likelihood of harm to the person.

- The person should be provided with the necessary care, treatment and support in the least invasive manner and in the least restrictive environment compatible with the delivery of safe and effective care. The perception of the restriction by the person himself should be taken into account.

- There should be clear guidance on the use of restrictive practices such as restraint, seclusion and time out for both adults and children, and these should be monitored and subject to evaluative research.

- There should be clear guidance on how and when research may be carried out with persons who have impaired decision-making capacity and this should be monitored.

4. These principles should apply in a non-discriminatory and balanced way to all healthcare decisions, as well as to welfare and financial needs.

5. Grounds for interfering with a person's autonomy should be based on his or her impaired decision-making capacity.

6. The definition used in the Mental Capacity Act 2005 should be adopted in Northern Ireland, specifically that:

   "a person lacks capacity if in relation to a matter at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary."

   Impairment of, or disturbance in the functioning of, the mind or brain includes mental disorder, as defined in the Mental Health (Northern Ireland) Order 1986, which subsumes "mental illness, mental handicap and any other disorder or disability of mind". It includes disorders due to injury or disease such as stroke. The test of capacity should include all those aspects of mental functioning which affect decision-making capacity (not just cognitive impairment).

7. Children and young people under the age of 18 who are affected by the proposed approach to substitute decision-making should be afforded special protections.

8. A comprehensive legislative framework must take account of the particular needs and protections necessary for vulnerable adults, including those compliant persons with impaired decision-making capacity who are deprived of their liberty ("Bournewood" situations).

9. Persons who are subject to the Criminal Justice System should have access to assessment, treatment and care which is equivalent to that available to all other people.

10. Legislation must provide appropriate public and individual protection to the community against harm from persons who decision-making capacity is impaired and who present a risk to others. On the other hand, legislation must not discriminate unjustifiably against persons who suffer from a mental health problem or learning disability."[293]

[293] The Bamford Review, *op. cit*.

Appendix 2 – Legislative Definitions of Mental Illness/Disorder

Mental Health Act 1983 (England)
In this Act
"mental disorder" means mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind and " mentally disordered " shall be construed accordingly.

Mental Health Act (Scotland) 1984
In this Act
“Mental disorder” means mental illness or mental handicap however caused or manifested;

The Mental Health (Northern Ireland) Order 1986
Definition of “mental disorder” and related expressions
1) In this Order—
“mental disorder” means mental illness, mental handicap and any other disorder or disability of mind;
“mental illness” means a state of mind which affects a person's thinking, perceiving, emotion or judgment to the extent that he requires care or medical treatment in his own interests or the interests of other persons;
“mental handicap” means a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning;
“severe mental handicap” means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning;
“severe mental impairment” means a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning and is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.
(2) No person shall be treated under this Order as suffering from mental disorder, or from any form of mental disorder, by reason only of personality disorder, promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.

Mental Health Act (Prince Edward Island)
“mental disorder” means a substantial disorder of thought, mood, perception, orientation or memory that seriously impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life and includes a mental disorder resulting from alcohol or drug addiction or abuse, but a mental handicap or learning disability does not, of itself, constitute mental disorder;

Mental Health Act (Alberta)
“mental disorder” means a substantial disorder of thought, mood, perception, orientation or memory that grossly impairs
(i) judgment:
(ii) behaviour,

(iii) capacity to recognize reality,
(iv) ability to meet the ordinary demands of life;

Mental Health Act (British Columbia)
"person with a mental disorder" means a person who has a disorder of the mind that requires treatment and seriously impairs the person's ability
(a) to react appropriately to the person's environment, or
(b) to associate with others;

Mental Health Act (Northern West Territories)
"mental disorder" means a substantial disorder of thought, mood, perception, orientation or memory, any of which grossly impairs judgment, behavior, the capacity to recognize reality or the ability to meet the ordinary demands of life but mental retardation or a learning disability does not of itself constitute a mental disorder; (*troubles mentaux*)

Mental Health Act (Ontario)
“mental disorder” means any disease or disability of the mind; (“trouble mental”)

Mental Health Act (Yukon)
“mental disorder” means a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behaviour, capacity to recognize reality, or ability to meet the ordinary demands of life;

Mental Health (Compulsory Assessment and Treatment) Act 1992 (New Zealand)
“mental disorder”, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it –
(a) Poses a serious danger to the health or safety of that person or of others; or
(b) Seriously diminishes the capacity of that person to take care of himself or herself; -
And mentally disordered, in relation to any such person, has a corresponding meaning.

Mental Health and Related Services Act (Northern Territory)
(1) In this Act, *mental illness* means a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person in one or more of the areas of thought, mood, volition, perception, orientation or memory and is characterised:

(a) by the presence of at least one of the following symptoms:
(i) delusions;
(ii) hallucinations;
(iii) serious disorders of the stream of thought;
(iv) serious disorders of thought form;
(v) serious disturbances of mood; or

(b) by sustained or repeated irrational behaviour that may be taken to indicate the presence of at least one of the symptoms referred to in paragraph (a).

(2) A determination that a person has a mental illness is only to be made in accordance with internationally accepted clinical standards.

(3) A person is not to be considered to have a mental illness merely because he or she:

(a) expresses or refuses or fails to express a particular political or religious opinion or belief, a particular philosophy or a particular sexual preference or sexual orientation;
(b) engages, or refuses or fails to engage, in a particular political, religious or cultural activity;
(c) engages, or has engaged, in sexual promiscuity, immoral or illegal conduct or anti-social behaviour;
(d) has a sexual disorder;
(e) is intellectually disabled;
(f) uses alcohol or other drugs;
(g) has a personality disorder or a habit or impulse disorder;
(h) has, or has not, a particular political, economic or social status;
(j) communicates, or refuses or fails to communicate, or behaves or refuses or fails to behave, in a manner consistent with his or her cultural beliefs, practices or mores;
(k) is, or is not, a member of a particular cultural, racial or religious group;
(m) is involved, or has been involved, in family or professional conflict;
(n) has been treated for mental illness or has been detained in a hospital that provides treatment of mental illness;
(p) has been admitted as an involuntary patient on the grounds of mental disturbance; or
(q) has acquired brain damage.

Mental Health Act 2007 (New South Wales)
mental illness means a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:

(a) delusions,
(b) hallucinations,
(c) serious disorder of thought form,
(d) a severe disturbance of mood,
(e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)–(d).

Mentally ill persons
(cf 1990 Act, s 9)

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

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

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

Mentally disordered persons
(cf 1990 Act, s 10)
A person (whether or not the person is suffering from mental illness) is a mentally
disordered person if the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary:

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

Mental Health (Treatment and Care) Act 1994 (Australian Capital Territory)
mental dysfunction means a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion.
mental illness means a condition that seriously impairs (either temporarily or permanently) the mental functioning of a person and is characterised by the presence in the person of any of the following symptoms:

(a) delusions;
(b) hallucinations;
(c) serious disorder of thought form;
(d) a severe disturbance of mood;
(e) sustained or repeated irrational behaviour indicating the presence of the symptoms referred to in paragraph (a), (b), (c) or (d).

mental impairment—see the Criminal Code, section 27.
Criminal Code 2002
(1) In this Act: ***mental impairment*** includes senility, intellectual disability, mental illness, brain damage and severe personality disorder.

(2) In this section: ***mental illness*** is an underlying pathological infirmity of the mind, whether of long or short duration and whether permanent or temporary, but does not include a condition (a ***reactive condition***) resulting from the reaction of a healthy mind to extraordinary external stimuli.

(3) However, a reactive condition may be evidence of a mental illness if it involves some abnormality and is prone to recur.

Mental Health Act 1986 (Victoria)
mental disorder includes mental illness;
mental illness has the meaning given in section 8

Criteria for involuntary treatment
(1) The criteria for the involuntary treatment of a person under this Act are that—

(a) the person appears to be mentally ill; and
(b) the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order; and
(c) because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and
(d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and
(e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

Note
In considering whether a person has refused or is unable to consent to treatment, see section 3A.
(1A) Subject to subsection (2), a person is mentally ill if he or she has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory.
(2) A person is not to be considered to be mentally ill by reason only of any one or more of the following—

(a) that the person expresses or refuses or fails to express a particular political opinion or belief;
(b) that the person expresses or refuses or fails to express a particular religious opinion or belief;
(c) that the person expresses or refuses or fails to express a particular philosophy;
(d) that the person expresses or refuses or fails to express a particular sexual preference or sexual orientation;
(e) that the person engages in or refuses or fails to engage in a particular political activity;
(f) that the person engages in or refuses or fails to engage in a particular religious activity;
(g) that the person engages in sexual promiscuity;
(h) that the person engages in immoral conduct;
(i) that the person engages in illegal conduct;
(j) that the person is intellectually disabled;
(k) that the person takes drugs or alcohol;
(l) that the person has an antisocial personality;

(m) that the person has a particular economic or social status or is a member of a particular cultural or racial group.

(3) Subsection (2)(k) does not prevent the serious temporary or permanent physiological, biochemical or psychological effects of drug or alcohol taking from being regarded as an indication that a person is mentally ill.

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Private Witness 3

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List of Witnesses — Attachment 1

Abel, Tony

Advocacy Tasmania Inc

Crawshaw, Dr John, Mental Health Services

Dawson, Professor John

Fitz, Bob

Fox, Chris, Mental Health Services South

Graham, James

Guardianship and Administration Board/Mental Health Tribunal

Lane, Dannii, Independent Mental Health Consumer Advocate

Lawler, Dr Tony, Royal Hobart Hospital

MacDonald, Dr Alasdair, Launceston General Hospital

Maharajh, Dr Manilall, Mental Health Services North

Malpas, Professor Jeff

McArthur, Dr Milford, Royal Hobart Hospital

McSherry, Professor Bernadette

Mental Health Council of Tasmania

Mental Health Review Board of Victoria

Muskett, Coral, Mental Health Services

New South Wales Law Reform Commission

New South Wales Mental Health Review Tribunal

Oakley Browne, Professor Mark, Mental Health Services South

Pielage, Dr Paul, Launceston General Hospital

Police Association of Tasmania

Richmond Fellowship of Tasmania Inc

Rosenman, Dr Stephen

Rudziewicz, Phillip

Schneider, Dr Rosemary

Skipworth, Dr Jeremy

Tasmania Police

Tasmanian Council of Social Service

Tasmanian Law Reform Institute

The Royal Australian and New Zealand College of Psychiatrists (Tasmanian Branch)

Tudehope, Dr Jenny, Mental Health Services North West

PLUS EIGHT PRIVATE WITNESSES

Written submissions taken into evidence Attachment 2

Abel, Tony

Advocacy Tasmania

Anglicare Tasmania

Australian Nursing Federation (Tasmanian Branch)

Barrington, Jonathon

Dawson, Professor John

Graham, James

Guardianship and Administration Board/Mental Health Tribunal

Hardie, Roger and Diane

Lane, Dannii, Independent Mental Health Consumer Advocate

Legal Aid Commission of Tasmania

Mental Health Council of Tasmania

Office of the Anti-Discrimination Commissioner

Richmond Fellowship of Tasmania

The Royal Australian and New Zealand College of Psychiatrists (Tasmanian Branch)

Schneider, Dr Rosemary

Tasmanian Council of Social Service

Tasmanian Government

PLUS EIGHT PRIVATE WRITTEN SUBMISSIONS

Documents taken into evidence — Attachment 3

Report on Continuing Investigation of Mental Health Services (MHS)

Verbal Presentation to the Legislative Council's Select Committee on Mental Health Legislative Measures

Investigation and Report of the Tasmanian Mental Health Service and Associated Organisations by Phillip Rudziewicz

Guardianship and Administration Board – An application for guardianship by Mental Health Services

The Chief Psychiatrist – Victoria, Australia (role and functions)

Code Black Breakdown

HR Law Resource Centre – Mental Health: Kracke v Mental Health Review Board & Ors (April 2009) – VCAT Makes Declaration of Breach of Human Rights in Major Charter Test Case

Victorian Government Solicitor's Office – Charter of Human Rights Newsletter – Krake v Mental Health Review Board & Ors (General) [2009] VCAT 646 April 2009

Rethinking Mental Health Laws – An Integrated Approach

Letter dated 24 March 2009 from Dr E V R Ratcliff enclosing a report "Cost effectiveness of early intervention for psychosis" by Access Economics Pty Limited for ORYGEN Research Centre

Email dated Tuesday, 31 March 2009 from Anna Mayo attaching the NHHRC Interim Report

Email dated Friday, 27 March 2009 from Anna Mayo attaching the ABS National Survey of Mental Health and Wellbeing: Summary of Results and DHHS Consumer and Carer Participation Framework

Email dated 12 May 2009 from Alison Merridew, Legal Officer, NSW Law Reform Commission providing attachments and additional references for the Committee's information

Mental Health (Compulsory Assessment and Treatment) Act 1992

Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992

Powerpoint Presentation – Rajiv Singh

Police Custody Charge Sheet

Borderline Personality Disorder: Foundations of Treatment – Krawitz and Watson

DBT Skills Manual – Waikato District Health Board

Letter dated 12 June 2009 from Lara Giddings MP, Deputy Premier and Minister for Health providing quantifiable data in relation to a range of staffing and patient matters requested at Public Hearing on 19 March 2009

International Journal of Law and Psychiatry – "A comparison of mental health legislation from diverse Commonwealth jurisdictions"

Legal Issues – Mental Health Laws for those 'Compliant' with Treatment, Damien Bruckard and Bernadette McSherry

Minutes of Proceedings Attachment 4

LEGISLATIVE COUNCIL SELECT COMMITTEE

MENTAL HEALTH LEGISLATIVE MEASURES

MINUTES

TUESDAY, 2 SEPTEMBER 2008

The Committee met 1.45 pm in Committee Room 3, Parliament House, Hobart.

Members Present: Mr Dean, Ms Forrest, Mr Martin and Mr Wilkinson

In Attendance: Mrs Sue McLeod, Clerk-Assistant (Secretary)
Ms Allison Waddington (Assistant)

Order of Parliament:

The Order of the Parliament appointing the Committee dated 28 August 2008, having been circulated, was taken as read.

Election of the Chair:

Ms Forrest was elected Chair and took the Chair.

Business:

Resolved:

(a) That witnesses be heard under Statutory Declaration.

(b) That evidence be recorded verbatim unless otherwise ordered by the Committee.

(c) That advertisements be inserted in the early general news pages of the three daily Tasmanian newspapers on Saturday, 6 September 2008 and that receipt of written submissions be conditioned for closure on Friday, 31 October 2008. The draft advertisement was agreed to. Advertisements to be placed in early general news pages again on Saturday, 4 October 2008.

(d) That the Secretary send invitations to make submissions to those on the list provided by the Chair, as well as –

- Courts (Mental Health), Magistrates Court (Jim Connolly)
- Centacare Tasmania

- City Mission
- Salvation Army
- St Michael's Association Inc.
- Anti-Discrimination Commissioner
- National Disability Service – Margaret Reynolds

(e) agreed to draft media release and agreed that it be sent to all media today, Tuesday 2 September 2008.

At 2.03 pm the Committee adjourned until a date to be advised.

LEGISLATIVE COUNCIL SELECT COMMITTEE

MENTAL HEALTH LEGISLATIVE MEASURES

MINUTES

THURSDAY, 12 FEBRUARY 2009

The Committee met 8.43 am in Committee Room 2, Parliament House, Hobart.

Members Present: Mr Dean, Ms Forrest, Mr Martin and Mr Wilkinson

In Attendance: Mrs Sue McLeod, Clerk-Assistant (Secretary)

Confirmation of Minutes:

The Minutes of the meeting held on Tuesday, 2 September 2008 were confirmed as a true and accurate record.

Correspondence:

Resolved, That the following correspondence be received –

- Letter dated 8 September 2008 from Philip and Diana Rudziewicz regarding issues relating to Mental Health Services.

- In Camera Correspondence

- In Camera Correspondence

- In Camera Correspondence

- Letter dated 22 September 2008 from Lara Giddings MP, Minister for Health, accepting the invitation for Department to make a written submission and departmental officers to present verbal evidence to the Committee.

- Letter dated 20 October 2008 from Dr Stuart Hooper, Chairman, Tasmanian Branch, RANZCP regarding participation in the Committee's inquiry. (The Secretary phoned Dr Hooper on 28/10/08 to clarify issues of concern)

- Letter dated 29 October 2008 from Mr Garry Fletcher, CEO, Hobart City Mission advising that the Mission is not in a position to comment on the appropriateness or otherwise of the legislation governing Mental Health. (Acknowledgement sent 30/10/08)

- Letter (undated) from Jim Cox, Minister for Police and Emergency Management regarding whole of government submission to be provided to Committee.

- Letter (undated) from Lara Giddings, MP, Minister for Health and Lin Thorp MLC, Minister for Human Services regarding whole of government submission to be provided to Committee.

- Letter dated 29 October 2008 from Mr James Graham acknowledging Committee's letter of 27 October 2008.

- Email dated 14 November 2008 from Katrina Aird, Office of the Anti-Discrimination Commission advising that Commissioner declines the offer to attend public hearings.

- Letter dated 10 December 2008 from Anita Smith, President, Guardianship and Administration Board providing a copy of an article by Dr Stephen Rosenman – 'Efficacy of Continuing Advocacy in Involuntary Treatment'.

- Letter dated 20 December 2008 from Roger and Diane Hardie advising they will be unable to attend public hearings.

- Email dated 22 December 2008 from Ken Hardaker advising Valerie Williams and Ken Hardaker will be attending public hearings.

- Letter dated 26 January 2009 from James Graham accepting offer to provide verbal evidence.

- Letter dated 27 January 2009 from David Bartlett MP, Premier, advising Dr John Crawshaw will provide verbal evidence to Committee on behalf of Government.

- In Camera Correspondence

- Letter dated 24 November 2008 from Anita Smith, President, Guardianship and Administration Board enclosing "Out to Pasture: A Case for the Retirement of Canadian Mental Health Legislation".

Submissions and Requests to Present Verbal Evidence:

Resolved, That the following submissions and requests be received –

1) Roger and Diane Hardie
2) Val Shelton-Bunn
3) Office of the Anti-Discrimination Commissioner
4) In Camera
5) In Camera
6) In Camera
7) In Camera
8) Guardianship and Administration Board/Mental Health Tribunal
9) In Camera
10) James Graham
11) In Camera
12) Advocacy Tasmania
13) Mental Health Council of Tasmania
14) Independent Mental Health Consumer Advocate
15) Anglicare Tasmania
16) Richmond Fellowship of Tasmania
17) Tasmanian Council of Social Service (TasCOSS)
18) Jonathon Barrington
19) Dr Rosemary Schneider
20) Professor John Dawson
21) Tony Abel
22) In Camera
23) Legal Aid Commission of Tasmania
24) Australian Nursing Federation (ANF)
25) Tasmanian Government
26) Royal Australian and New Zealand College of Psychiatrists
27) In Camera

Document Received:

Resolved, That the following document be received –

- Report on Continuing Investigation of Mental Health Services (MHS) (Philip Rudziewicz)

Public Hearings:

DR ROSEMARY SCHNEIDER was called, made the Statutory Declaration and was examined.

The witness withdrew.

MS DEBORAH RIGBY AND MS ANITA SMITH, on behalf of the Guardianship and Administration BOARD and Mental Health Tribunal were called, made the Statutory Declaration and were examined.

Mr Wilkinson withdrew at 9.50 am.

The witnesses withdrew.

MS VALERIE WILLIAMS AND MR KEN HARDAKER on behalf of Advocacy Tasmania Inc were called, made the Statutory Declaration and was examined.

Mr Wilkinson took his place.

The witnesses withdrew.

The Committee suspended at 10.55 am.
The Committee resumed at 11.08 am.

MS MICHELLE SWALLOW on behalf of Mental Health Council of Tasmania was called, made the Statutory Declaration and was examined.

The witness withdrew.

MR TONY ABEL was called, made the Statutory Declaration and was examined.

The witness withdrew.

MS DANNI LANE, Independent Mental Health Consumer Advocate was called, made the Statutory Declaration and was examined.

Tabled Document :

Verbal Presentation to the Legislative Council's Select Committee on Mental Health Legislative Measures (14)

The witness withdrew.

The Committee suspended at 1.15 pm.
The Committee resumed at 2.30 pm.

MR MARTIN GIBSON on behalf of the Tasmanian Council of Social Service (TasCOSS) was called, made the Statutory Declaration and was examined.

The witness withdrew.

MR PATRICK CARLISLE on behalf of the Richmond Fellowship of Tasmania was called, made the Statutory Declaration and was examined.

Mr Wilkinson took his place.

The witness withdrew.

The Committee suspended at 4.08 pm.
The Committee resumed at 4.20 pm.

DR JOHN CRAWSHAW, on behalf of the DEPARTMENT OF HEALTH AND HUMAN SERVICES was called, made the Statutory Declaration and was examined.

The witness withdrew.

At 5.52 pm the Committee adjourned until a Friday, 13 February 2009.

LEGISLATIVE COUNCIL SELECT COMMITTEE

MENTAL HEALTH LEGISLATIVE MEASURES

MINUTES

FRIDAY, 13 FEBRUARY 2009

The Committee met 9.07 am in Committee Room 2, Parliament House, Hobart.

Members Present: Mr Dean, Ms Forrest, Mr Martin and Mr Wilkinson

In Attendance: Mrs Sue McLeod, Clerk-Assistant (Secretary)

Confirmation of Minutes:

The Minutes of the meeting held on Thursday, 12 February 2009 were confirmed as a true and accurate record.

Private Hearings:

A PRIVATE WITNESS was called, made the Statutory Declaration and was examined.

Tabled Document :

Verbal Evidence (11)

The witness withdrew.

A PRIVATE WITNESS was called, made the Statutory Declaration and was examined.

Tabled Document :

Mental Health Legislative Measures – More Notes (9)

The witness withdrew.

The Committee suspended at 10.10 am.
The Committee resumed at 10.30 am.

Mr James Graham was called, made the Statutory Declaration and were examined.

The witness withdrew.

A PRIVATE WITNESS was called, made the Statutory Declaration and was examined.

Tabled Document :

In Camera Document

The witness withdrew.

A PRIVATE WITNESS was called, made the Statutory Declaration and was examined.

The witness withdrew.

Other Business :

The Committee discussed its future program and agreed to meet with the person in charge of the –

- Department of Emergency Medicine in each region;
- Department of Psychiatric Medicine at the Royal Hobart Hospital;
- PICU at the Royal Hobart Hospital;
- Spencer Clinic in Burnie; and
- Ward 1E at the Launceston General Hospital.

The Committee also requested that the Police Minister and the Police Association be invited to give verbal evidence, as well as the College of Psychiatrists.

At 1.00 pm the Committee adjourned until a Tuesday, 17 February 2009.

LEGISLATIVE COUNCIL SELECT COMMITTEE

MENTAL HEALTH LEGISLATIVE MEASURES

MINUTES

TUESDAY, 17 FEBRUARY 2009

The Committee met 11.00 am in the 4th floor Conference Room, Henty House, Launceston

Members Present: Mr Dean, Ms Forrest, Mr Martin and Mr Wilkinson

In Attendance: Mrs Sue McLeod, Clerk-Assistant (Secretary) Allison Waddington (Assistant to Secretary)

Confirmation of Minutes:

The Minutes of the meeting held on Friday, 13 February 2009 were confirmed as a true and accurate record.

Private/Public Hearings:

A PRIVATE WITNESS was called, made the Statutory Declaration and was examined.

Tabled Document :

Notes (28)

The witness withdrew.

A PRIVATE WITNESS was called, made the Statutory Declaration and was examined.

Tabled Document :

In Camera Document

The witness withdrew.

A PRIVATE WITNESS was called, made the Statutory Declaration and was examined.

The witness withdrew.

A PRIVATE WITNESS was called, made the Statutory Declaration and was examined.

The witness withdrew.

The Committee suspended at 1.18 pm.
The Committee resumed at 2.05 pm.

Public/Private Hearings cont'd.

Mr Bob Fitz was called (part 'in camera'), made the Statutory Declaration and was examined.

The witness withdrew.

Mr Phillip Rudziewicz was called, made the Statutory Declaration and was examined.

Tabled Document :

Investigation and Report of the Tasmanian Mental Health Service and Associated Organisations by Phillip Rudziewicz (30)

The witness withdrew.

Other Business:

Resolved, That –

- Dr John Crawshaw be provided with a copy of his transcript.
- As well as hearings with relevant mental health professionals, that the Committee visit Tyenna and the Rocherlea Mental Health Centre.
- The Secretary request quantifiable statistics from the Mental Health Department regarding the number of patients, staff, those turned away, those that access each service, those discharged after 5 pm and who to and any other relevant data.
- Further hearings be held in Hobart on 19 March and Launceston on 23 March.

At 3.45 pm the Committee adjourned until 19 March 2009.

LEGISLATIVE COUNCIL SELECT COMMITTEE

MENTAL HEALTH LEGISLATIVE MEASURES

MINUTES

THURSDAY, 19 MARCH 2009

The Committee met at 10.53 am in Committee Room 2, Parliament House, Hobart.

Apology: Mr Dean (morning only)

Members Present: Ms Forrest, Mr Martin and Mr Wilkinson

In Attendance: Mrs Sue McLeod, Clerk-Assistant (Secretary)

Confirmation of Minutes:

The Minutes of the meeting held on Tuesday, 17 February 2009 were confirmed as a true and accurate record.

Correspondence:

Resolved, That the following correspondence be received –

- Email dated 24 February 2009 regarding phone message from Christine Walker from RANZP advising Eric Ratcliffe will be representing the College at the Launceston hearings.

- Letter dated 24 February 2009 from Jim Cox MP, Minister for Police and Emergency Management advising officers from his Department will be attending hearing on 19 March 2009.

- In Camera Correspondence

- Letter dated 11 March 2009 from Lara Giddings, MP, Minister for Health regarding Departmental officers attending Committee hearings.

Submissions:

Resolved, That the following submission be received –

21) Tony Abel

Documents:

Resolved, That the following document be received –

Guardianship and Administration Board – An application for guardianship by Mental Health Services

Other Business:

Resolved, That public hearing transcripts be placed on the Committee website.

Public Hearings:

INSPECTOR MARK MEWIS, on behalf of Tasmania Police, was called, made the Statutory Declaration and was examined.

The witness withdrew.

Dr John Crawshaw, Chief Executive Officer; Professor Mark Oakley Browne, Statewide Clinical Director; and Mr Chris Fox, Southern Area Manager, for the Psychiatric Intensive Care Unit, were called, made the Statutory Declaration and was examined.

Tabled Document:

The Chief Psychiatrist – Victoria, Australia (role and functions)

The witnesses withdrew.

The Committee suspended at 1.20 pm.

Mr Wilkinson withdrew.

The Committee resumed at 2.04 pm.

Mr Dean took his place.

Public Hearings:

Mr Randolph Wierenga, President, Police Association of Tasmania, was called, made the Statutory Declaration and was examined.

The witness withdrew.

The Committee suspended at 2.55 pm.
The Committee resumed at 3.00 pm.

Dr Milford McArthur, Clinical Director, Department of Psychological Medicine and Dr Tony Lawler, Director of Emergency Medicine were called, made the Statutory Declaration and was examined.

Mr Wilkinson took his place at 3.27 pm.

Tabled Document:

Code Black Breakdown

The witnesses withdrew.

At 4.47 pm the Committee adjourned until Monday, 23 March 2009.

LEGISLATIVE COUNCIL SELECT COMMITTEE

MENTAL HEALTH LEGISLATIVE MEASURES

MINUTES

MONDAY, 23 MARCH 2009

The Committee met at 1.55 pm in the Conference Room, 4th Floor, Henty House, Launceston.

Members Present: Mr Dean, Ms Forrest, Mr Martin and Mr Wilkinson

In Attendance: Mrs Sue McLeod, Clerk-Assistant (Secretary)

Confirmation of Minutes:

The Minutes of the meeting held on Thursday, 19 March 2009 were confirmed as a true and accurate record.

Public Hearings:

DR JENNY TUDEHOPE, Spencer Clinic, DR ALASDAIR MACDONALD, Director of Medicine, LGH, DR MANILALL MAHARAJH, Ward IE, LGH, DR PAUL PIELAGE, Director, Department of Emergency Medicine, LGH and MS CORAL MUSKETT, Statewide Director of Nursing, were called, made the Statutory Declaration and were examined.

The witnesses withdrew.

The Committee suspended at 3.37 pm
The Committee resumed at 3.42 pm

DR ERIC RATCLIFF, on behalf of the Royal Australian and New Zealand College of Psychiatrists, was called, made the Statutory Declaration and was examined.

The witness withdrew.

Correspondence:

The Chair tabled an email dated 22 March 2009 to Ruth Forrest MLC from Alison Merridew, Legal Officer, NSW Law Reform Commission, regarding the definition of 'mentally ill person' in the NSW Act.

Other Business:

The Committee discussed its future program, including the need to arrange a date to visit Tyenna.

Mr Dean to provide the Secretary with details of the dates he is available for meetings/visit.

Resolved, That the Committee meet, if possible, with the following people in Hobart to receive verbal evidence –

Ian Sale, Private Psychiatrist
Chris Williams, Private Psychiatrist
Mike Hill, Mental Health Court

And the following, in Melbourne if possible –

Professor Greg James, Victoria
Alison Merridew, NSW Law Reform Commission
John Lesser, Mental Health Review Board, Victoria
Stephen Rosenman

The Committee also requested the Secretary contact Dr Manilall Maharajh regarding relevant contacts in New Zealand.

Resolved, That – As Ms Forrest and Mr Wilkinson will be in New Zealand for a Public Accounts Conference in April, that they be authorised to meet relevant mental health personnel on behalf of the Committee.

At 5.04 pm the Committee adjourned until a date to be determined.

LEGISLATIVE COUNCIL SELECT COMMITTEE

MENTAL HEALTH LEGISLATIVE MEASURES

MINUTES

TUESDAY, 5 MAY 2009

The Committee met at 8.00 am in The Lounge, Virgin Blue, Melbourne Airport, Melbourne.

Members Present: Ms Forrest, Mr Martin and Mr Wilkinson

In Attendance: Mrs Sue McLeod, Clerk-Assistant (Secretary)

Meetings :

The Committee met with –

MR JOHN LESSER, President of the Mental Health Review Board of Victoria.

Tabled Documents :

- HR Law Resource Centre – Mental Health : Kracke v Mental Health Review Board & Ors (April 2009) – VCAT Makes Declaration of Breach of Human Rights in Major Charter Test Case
- Victorian Government Solicitor's Office – Charter of Human Rights Newsletter – Krake v Mental Health Review Board & Ors (General) [2009] VCAT 646 April 2009

The witness withdrew.

PROFESSOR BERNADETTE McSHERRY

Tabled Document :

- Rethinking Mental Health Laws – An Integrated Approach

The witness withdrew.

The Committee suspended at 9.48 am

The Committee resumed at 2.35 pm in the Meeting Room, Level 14, NSW Law Reform Commission, 10 Spring Street, Sydney.

Meetings :

The Committee met with –

DR STEPHEN ROSENMAN

The witness withdrew.

PROFESSOR GREG JAMES, President, NSW Mental Health Review Tribunal, MS ALISON MERRIDEW, Legal Officer, NSW Law Reform Commission and MS SARAH HANSON, Forensic Team Leader, Mental Health Review Tribunal.

The witnesses withdrew.

At 5.08 pm the Committee adjourned until a date to be determined.

LEGISLATIVE COUNCIL SELECT COMMITTEE

MENTAL HEALTH LEGISLATIVE MEASURES

MINUTES

FRIDAY, 22 MAY 2009

The Committee met at 8.59 am in Committee Room No. 2, Parliament House, Hobart.

Members Present: Ms Forrest, Mr Martin and Mr Wilkinson

Apology: Mr Dean

In Attendance: Mrs Sue McLeod, Clerk-Assistant (Secretary)
Ms Emily Freeman, Research Officer

Correspondence:

Resolved, That the following correspondence be received -

- Letter dated 5 May 2009 from John Lesser, President, Mental Health Review Board of Victoria regarding today's committee meeting.

Documents:

Resolved, That the following documents be received –

- Letter dated 24 March 2009 from Dr E V R Ratcliff enclosing a report "Cost effectiveness of early intervention for psychosis" by Access Economics Pty Limited for ORYGEN Research Centre. (26)
- Email dated Tuesday, 31 March 2009 from Anna Mayo attaching the NHHRC Interim Report. (31)
- Email dated Friday, 27 March 2009 from Anna Mayo attaching the ABS National Survey of Mental Health and Wellbeing: Summary

of Results and DHHS Consumer and Carer Participation Framework. (31)

- Email dated 12 May 2009 from Alison Merridew, Legal Officer, NSW Law Reform Commission providing attachments and additional references for the Committee's information. (32)

Public Hearings:

ANITA SMITH, President, Guardianship Board and DEBRA RIGBY, President, Mental Health Tribunal, were called, made the Statutory Declaration and were examined.

Committee suspended at 9.23 am
Committee resumed at 9.24 am

The hearing continued.

The witnesses withdrew.

Committee suspended at 10.12 am
Committee resumed at 10.15 am

Dr Jeremy Skipworth, was called via phone link up, made the Statutory Declaration and was examined.

The witness withdrew.

Other Business:

The Chair tabled the following documents from New Zealand –

- Mental Health (Compulsory Assessment and Treatment) Act 1992
- Guidelines to the Mental Health (Compulsory Assessment and Treatment) Act 1992
- Powerpoint Presentation – Rajiv Singh
- Police Custody Charge Sheet
- Borderline Personality Disorder: Foundations of Treatment – Krawitz and Watson
- DBT Skills Manual – Waikato District Health Board

At 11.10 am the Committee adjourned until Monday, 25 May 2009.

LEGISLATIVE COUNCIL SELECT COMMITTEE

MENTAL HEALTH LEGISLATIVE MEASURES

MINUTES

MONDAY, 25 MAY 2009

The Committee met at 2.30 pm via video link, 24 Davey Street, Hobart.

Members Present: Mr Dean, Ms Forrest and Mr Wilkinson

Apology: Mr Martin

In Attendance: Mrs Sue McLeod, Clerk-Assistant (Secretary)
Ms Julie Thompson, Executive Assistant

Confirmation of Minutes:

The Minutes of the meeting held on Friday, 22 May 2009 were confirmed as a true and accurate record.

Meetings:

The Committee met with Alison Merridew, Legal Officer, NSW Law Reform Commission and Sarah Hanson, Forensic Team Leader, Mental Health Review Tribunal by video link.

Other Business:

The Secretary was requested to arrange a hearing with the Law Reform Commission in relation to Tasmania's human rights framework.

Future Program:

The Committee agreed to meet on Wednesday, 10 June at 9.30 am and Thursday, 11 June at 9.00 am.

At 3.35 pm the Committee adjourned until Wednesday, 10 June 2009.

LEGISLATIVE COUNCIL SELECT COMMITTEE

MENTAL HEALTH LEGISLATIVE MEASURES

MINUTES

THURSDAY, 11 JUNE 2009

The Committee met at 9.11 am in Committee Room 2, Parliament House, Hobart.

Members Present: Mr Dean, Ms Forrest and Mr Martin.

In Attendance: Mrs Sue McLeod, Clerk-Assistant (Secretary)
Ms Emily Freeman, Research Officer

Confirmation of Minutes:

The Minutes of the meeting held on Monday, 25 May 2009 were confirmed as a true and accurate record.

Issues for the Report:

The Committee discussed issues for inclusion in the Draft Report.

At 9.42 am Mr Wilkinson took his place.

The Committee Members requested copies of the Anglicare Report and media statement.

The Secretary was asked to contact the Minister's Office to ascertain when the draft legislation will be available.

Resolved, That when a draft report is available, the Committee call back Mr John Crawshaw, Ms Debra Rigby and Ms Anita Smith and possibly Professor Bernadette McSherry and Dr Eric Ratcliff to discuss the Committee's preliminary findings.

Future Program:

The Committee agreed to meet on Thursday, 18 June at 8.50 am to receive verbal evidence from the Law Reform Institute and Professor John Dawson, if possible.

At 10.21 am the Committee adjourned until Thursday, 18 June 2009.

LEGISLATIVE COUNCIL SELECT COMMITTEE

MENTAL HEALTH LEGISLATIVE MEASURES

MINUTES

THURSDAY, 18 JUNE 2009

The Committee met at 9.02 am in Committee Room 2, Parliament House, Hobart.

Members Present: Mr Dean, Ms Forrest and Mr Wilkinson

In Attendance: Mrs Sue McLeod, Clerk-Assistant (Secretary)
Ms Emily Freeman, Research Officer

Meeting via Phone-link:

The Committee met with PROFESSOR JOHN DAWSON via phone-link.

Mr Martin took his place at 9.17 am

The witness withdrew.

Public Hearings:

TERESE HENNING, Board Member Tasmanian Law Reform Institute, was called, made the Statutory Declaration and was examined.

The witness withdrew.

Confirmation of Minutes:

The Minutes of the meeting held on Thursday, 11 June 2009 were confirmed as a true and accurate record.

Document:

Resolved, That the following document be received –

- Letter dated 12 June 2009 from Lara Giddings MP, Deputy Premier and Minister for Health providing quantifiable data in relation to a range of staffing and patient matters requested at Public Hearing on 19 March 2009. (25)

Tabled Document:

International Journal of Law and Psychiatry - "A comparison of mental health legislation from diverse Commonwealth jurisdictions".

Other Business:

The Chair moved that the Committee's previous motion of 11 June 2009 that "when a draft report is available, the Committee call back Mr John Crawshaw, Ms Debra Rigby and Ms Anita Smith and possibly Professor Bernadette McSherry and Dr Eric Ratcliff to discuss the Committee's preliminary findings", be rescinded.

The motion was agreed to.

The Committee discussed issues for inclusion in the draft report.

The Chair advised she would contact the Minister for Health regarding the current status of the draft legislation.

At 10.33 am the Committee adjourned until a date to be determined.

LEGISLATIVE COUNCIL SELECT COMMITTEE

MENTAL HEALTH LEGISLATIVE MEASURES

MINUTES

THURSDAY, 13 AUGUST 2009

The Committee met at 9.12 am in Committee Room 3, Parliament House, Hobart.

Members Present: Mr Dean, Ms Forrest, Mr Martin and Mr Wilkinson

In Attendance: Mrs Sue McLeod, Clerk-Assistant (Secretary)
Ms Emily Freeman, Research Officer

Confirmation of Minutes:

The Minutes of the meeting held on Thursday, 18 June 2009 were confirmed as a true and accurate record.

Business Arising:

The Chair advised that she had spoken to the Minister and that the Mental Health Bill would not be presented to this current Parliament.

Correspondence:

Resolved, That the following correspondence be received -

- Letter dated 6 July 2009 from Lawrence McDonald, Head of Secretariat, Steering Committee for the Review of Government Service Provision enclosing a copy of the Overcoming Indigenous Disadvantage: Key Indicators 2009 Report

Document:

Resolved, That the following document be received -

- "Legal Issues - Mental Health Laws for those "Compliant" with Treatment", Damien Bruckard and Bernadette McSherry (35).

Public Hearings:

PROFESSOR JEFF MALPAS, Professor of Philosophy, University of Tasmania was called, made the Statutory Declaration and was examined.

The witness withdrew.

The Committee suspended at 10.25 am.
The Committee resumed at 10.45 am.

Report Deliberations:

The Committee considered the Draft Report (as at 7 August 2009).

Resolved, That quotes in the report from evidence regarding individual personal situations should not indicate names and that the evidence be retained "in camera".

The Committee suspended at 12.35 pm.
The Committee resumed at 1.41 pm.

Report Deliberations:

The Committee further considered the Draft Report (as at 7 August 2009).

Mr Wilkinson withdrew at 3.30 pm.

Future Program:

Resolved, That in addition to the previously arranged meeting dates of 18 and 25 August, that a further meeting be scheduled for 8.30 am on Tuesday, 1 September 2009.

At 3.35 pm the Committee adjourned until Tuesday, 18 August 2009.

LEGISLATIVE COUNCIL SELECT COMMITTEE

MENTAL HEALTH LEGISLATIVE MEASURES

MINUTES

TUESDAY, 18 AUGUST 2009

The Committee met at 11.17 am in Committee Room 2, Parliament House, Hobart.

Members Present: Mr Dean, Ms Forrest, Mr Martin and Mr Wilkinson

In Attendance: Mrs Sue McLeod, Clerk-Assistant (Secretary)

Confirmation of Minutes:

The Minutes of the meeting held on Thursday, 13 August 2009 were confirmed as a true and accurate record.

Report Deliberations:

The Committee considered the Draft Report (as at 17 August 2009).

The Committee suspended at 1.00 pm.
The Committee resumed at 2.20 pm.

Report Deliberations:

The Committee further considered the Draft Report (as at 17 August 2009).

Mr Wilkinson took his place at 2.23 pm.

Future Program:

The Committee agreed to meet again, as follows –

9.00 – 10.00 am	Tuesday, 25 August
8.30 – 10.00 am	Tuesday, 1 September
11.30 – 2.30 pm	Friday, 11 September

At 5.00 pm the Committee adjourned until Tuesday, 25 August 2009.

LEGISLATIVE COUNCIL SELECT COMMITTEE

MENTAL HEALTH LEGISLATIVE MEASURES

MINUTES

TUESDAY, 25 AUGUST 2009

The Committee met at 9.07 am in Committee Room 2, Parliament House, Hobart.

Members Present: Mr Dean, Ms Forrest and Mr Wilkinson

In Attendance: Mrs Sue McLeod, Clerk-Assistant (Secretary)

Confirmation of Minutes:

The Minutes of the meeting held on Tuesday, 18 August 2009 were confirmed as a true and accurate record.

Report Deliberations:

The Committee considered the Draft Report (as at 24 August 2009), Chapters 5 and 6 (page by page) and the Recommendations.

Mr Martin took his place at 10.02 am.

At 10.05 am the Committee adjourned until Tuesday, 1 September 2009.

LEGISLATIVE COUNCIL SELECT COMMITTEE

MENTAL HEALTH LEGISLATIVE MEASURES

MINUTES

TUESDAY, 1 SEPTEMBER 2009

The Committee met at 8.36 am in Committee Room 2, Parliament House, Hobart.

Members Present: Mr Dean, Ms Forrest and Mr Wilkinson

In Attendance: Mrs Sue McLeod, Clerk-Assistant (Secretary)

Confirmation of Minutes:

The Minutes of the meeting held on Tuesday, 25 August 2009 were confirmed as a true and accurate record.

Mr Martin took his place at 8.40 am.

Report Deliberations:

The Committee considered the Draft Report (as at 1 September 2009), page by page.

Resolved, That the Final Draft be considered later this week and that the Report be Tabled during Mental Health Week on 6 October 2009.

At 10.00 am the Committee adjourned until a date to be advised.

LEGISLATIVE COUNCIL SELECT COMMITTEE

MENTAL HEALTH LEGISLATIVE MEASURES

MINUTES

THURSDAY, 3 SEPTEMBER 2009

The Committee met at 8.51 am in Committee Room 2, Parliament House, Hobart.

Members Present: Mr Dean, Ms Forrest and Mr Wilkinson

In Attendance: Mrs Sue McLeod, Clerk-Assistant (Secretary)

Confirmation of Minutes:

The Minutes of the meeting held on Tuesday, 1 September 2009 were confirmed as a true and accurate record.

Mr Martin took his place at 9.03 am.

Report Deliberations:

The Committee considered the Final Draft Report (as at 3 September 2009), page by page.

Resolved, That –

- The Final Draft be agreed to with minor amendment.
- The Report be Tabled at 11 am on Tuesday, 6 October 2009;
- A media conference be arranged for 1.00 pm on Tuesday, 6 October 2009; and that
- A media release be prepared.

At 9.20 am the Committee adjourned sine die.