

**THE LEGISLATIVE COUNCIL SELECT COMMITTEE ON MENTAL HEALTH  
LEGISLATIVE MEASURES MET IN COMMITTEE ROOM 2, PARLIAMENT  
HOUSE, HOBART, ON THURSDAY 12 FEBRUARY 2009.**

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**Dr ROSEMARY SCHNEIDER** WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

**CHAIR** (Ms Forrest) - Thank you, Rosemary, for coming along. Just some points before we start; the proceedings are being recorded and we will possibly use some of the evidence in our report. If there is anything that you believe should be in camera in relation to the evidence, particularly anything that's related to individuals or any other matter you believe should be in camera, you can make that request and the committee will consider it. The media are aware that our hearings are going on; they may be here. They might not find it as interesting as we do. If there is any time you feel you want to go into camera just make that request.

**Dr SCHNEIDER** - Okay, thank you.

**CHAIR** - We have received your submission and read it. It would help if you provided a bit of an overview. We do need to focus on the terms of reference which relate to the protective legislation that's in place and we are very aware of the current review of the Mental Health Act that's fairly well down the path at this stage and also the GABA and the ADA, which are not being reviewed currently. Just where you do see the future should be?

**Dr SCHNEIDER** - I don't know what your particular angle is or what you are really looking for but there's quite a big consumer movement that's been going on for years now, looking for more freedom and fewer restrictions on people receiving mental health treatment. I am very keen to counterbalance that because I think it can go too far. I think it's a pendulum swing thing and the problem is that if we're still harking back to things like Chelmsford, which I think a lot of people do - and there are still a lot of people who think that mental health treatment is like *One Flew Over the Cuckoo's Nest* - we need to say, hang on a minute; we've actually now already got masses of protections in place for people and I think we need to consider that the pendulum's probably gone quite far enough the other way.

**Mr WILKINSON** - When you're talking about Chelmsford, are you talking about the deep sleep treatment alone or -

**Dr SCHNEIDER** - I think it was the atmosphere of those things happening without scrutiny that was really relevant to this kind of inquiry and the whole idea that psychiatrists behind closed doors are doing appalling things to people who don't fight back. That was really the problem.

That particular treatment, obviously, shouldn't really have happened at all and there is a question of whether things like that could still arise and I think in people's minds it caused a doubt. Now there are numerous checks and balances and I listed them in my submission, and you'd already be aware of them, ranging from the criteria for the Mental

Health Act itself to the fact that there are automatic Mental Health Tribunal reviews of hospitalisation and the official visitors coming around the facilities. Patients are all required to be advised of their rights and that they can access advocacy services. Indeed, on top of all that there are informal people like consumer representatives and consultants who have now been appointed by the State services. I think that is quite a lot. I do not think there are terrible things happening behind closed doors.

**CHAIR** - I think one of the issues raised is the fact that the patients with mental health disorders who have capacity to make decisions regarding their treatment can still be put in a position where they cannot refuse that treatment; they are put on an order then they are treated. Whereas a person with a physical illness, such as hypertension, can be made well aware of their condition, they can be told the risks, and as long as they have capacity they can refuse treatment, although they potentially could have a stroke while driving and kill someone by causing a road traffic accident. There is a view, in some people's mind, that there is a difference for people with mental health disorders with capacity who are being denied that same right that people with physical or other illnesses have. Do you have a view on that?

**Dr SCHNEIDER** - 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. My view is it is extremely negligent not to take charge of those people's decision-making until you can at least get them as well as you can. Dying with your rights - I do not think that is very good. 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. It is also typically why there are enormous gaps between patients and their families. Families who see that someone has changed - sometimes in more subtle ways but sometimes it is very gross - are horrified at the amount of self-determination they have to cause themselves extreme grief. If the patient does not think they are suffering from an illness, that does not mean that they are not suffering. That is the trouble.

I guess families look at that from the trajectory of what their life would have been like when they started. A person who has left home, is in close relationships, has a job and starts to think that something odd is happening, will start to withdraw from people. That person is no longer able to handle the interpersonal relationships required to do their job, starts to turn against their family who do not agree with the grounds on which they have been making these changes in their life, becomes extremely isolated from everything, does not want treatment, does not see that there is anything wrong with them and their family have to stand by and watch that. At the moment even getting that person into hospital, particularly if it has been a slow slide rather than a sudden event, can be a battle because there has been a very conservative interpretation of harm to self and harm to others.

The legislation already provides for the risk of deterioration and, in fact, services are much less familiar with that and much less willing to argue with the Mental Health Tribunals, so that person cannot even be detained for someone to have a closer look at their life. I would argue that if they have reached the point where there is that much discrepancy in their life trajectory, I do not think it is doing them any good not to treat them. There is quite a well-known Canadian case which, unfortunately, I have not

brought with me, of a very articulate and educated man who was eventually detained under their legislation and could not be treated. It went as far as their high court and they decided against treating him. He ended up in hospital but untreated because there was a discrepancy between his ability to function in the community and his articulate arguments against being treated.

**CHAIR** - He must have been a volunteer admission to the hospital.

**Dr SCHNEIDER** - No, he wasn't.

**CHAIR** - How could they admit him but not treat him?

**Dr SCHNEIDER** - Because of the legislation gap. We have the same gap; detaining and treatment are two separate things.

**CHAIR** - Do you see that as an issue?

**Dr SCHNEIDER** - I do not think that makes any sense. I think it is appalling. There is no point in detaining someone if you cannot treat them. Having said that, we do not have the luxury anymore. When I trained there was still an atmosphere that you would admit people for observation. In London, we were trained that the Maudsley ideal was to admit someone for two weeks at the hospital before you made any decisions. Both those have gone as we do not have the resources for that kind of thing, even if people's lives would allow them two weeks of doing nothing. We have to make decisions quite quickly and usually you can gather the information, particularly from families, quite quickly and you know whether someone has fallen off their trajectory or not.

**Mr WILKINSON** - Should there be any time under the view of experts to see whether those people should or should not receive treatment? You were talking about two weeks.

**Dr SCHNEIDER** - I think ideally there would be. I do not think that is something we need to legislate. I think that services do their best anyway. I think, again, the pendulum if anything has gone too far the other way, that they will make a very quick decision to let someone go and they are biased towards that and not towards keeping them. That is partly because of resources and partly because attitude changes because, if you like, liberality has imbued the professions as well and we are in the same world as the patients.

**Mr WILKINSON** - New Norfolk, as you know, is no more. Do you think that is a good thing or do you think there should be somewhere for people to be detained for treatment more than they are now, because it seems that rather than a slow pendulum swing it was a sudden swing the other way?

**Dr SCHNEIDER** - There was a wave of idealism that swept the whole world and Tasmania followed, as it always does. Nobody really understood the level of resources it would take to replace the old mental hospitals and I do not think it is actually possible. That same book that I quoted in my working submission has some very interesting data about a very large international study done on trying to provide people with optimum treatment. After I think one to two years most of the centres in the study dropped out because they could not sustain providing that level of treatment to people resource-wise. Even with optimum treatment the rate of actual cure and total recovery was low.

Those people need ongoing high levels of care. I think that we should still be providing more of that in inpatient-type units. We gave up on Royal Derwent essentially because the culture was seen to be so bad and so irremediable that we rather wiped the slate clean. That has been the case around the world with the old mental health bins, it was hard to staff them and it was hard to keep a positive atmosphere of rehabilitation. I think we need to get back to more of that kind of level of protection of people and availability of long stay.

The other thing that I can say is that the average length of stay in an acute psychiatric wing is now somewhere around 12 days. The average length of time it takes for antipsychotic medication to start working is a bit longer than that. You can certainly sedate people quicker than that but to get a really good effect from their treatment is going to take much longer. The beds are not there to keep them and once they are out of the ordinary hospital beds there is a whole mish-mash of how to get through the services to maintain an intensive level of support. It is very, very difficult.

**Ms FORREST** - Are you suggesting we need to have something like a step-down facility? I think some of the problems at Ward 1E, for example, are readmissions and the reputation it seems to have acquired over a few years, not all related to the treatment, but also staff morale et cetera. In such a ward, where you have an acute service for acute mental health conditions, there is a delay in seeing how effective the treatment and medication of people who are being placed on antipsychotic medication is going to be. Can they be placed into another facility for a period of time or do we need to expand the acute service?

**Dr SCHNEIDER** - It depends on the level of care you are going to provide. I think that a lot of those people at the next level down still need almost as much intervention from staff as the people in the acute hospital, and that they do not get. The step-down already exists in Hobart at Mistral Place. That is always full as well. There are blockages at every step of the cascade of services. They are all overstretched.

In Launceston there never was a step-down. What they have done now - and this is probably contentious - is they have closed the Howard Hill Centre which was pretty much permanent stay, for which I think there is still a need, and they are replacing it with a two- to three-month stay, which would be more like a step-down. However, it is miles from the hospital with a different style of staffing, and it is not going to have that intensity. I think that is of less value than something that is more intensively staffed. 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 supermarket so they are not overwhelmed when they are suddenly faced with the real world again.

**CHAIR** - If there were a more comprehensive legislative framework that brought in the guardianship administration aspects of that lifestyle stuff, like helping people with their

accommodation, finances and day-to-day living, as well as the orders side of it for detainment and treatment under one auspicing body, would that be a better way to provide a more holistic approach?

**Dr SCHNEIDER** - I think it probably would, so long as we can marry up the two philosophies. As you know, the Mental Health Act is all for minimal restrictions and the guardianship legislation is slightly more inclusive and has the best-interests test in it. I personally am in favour of the best-interests test. I think it is more appropriate, but I think you will get a lot of consumers who fiercely resent that. We live in a time when people want personal freedom more than almost anything else and I don't think they sometimes realise where that ends up.

**CHAIR** - So the best-interest test can be a challenge in itself, is that what you're suggesting?

**Dr SCHNEIDER** - I don't know that consumers will necessarily like it, particularly those who are a bit better. The other issue is that we can only have one lot of legislation and I can't see a way to split it. There are vastly different types of people who sometimes come under its umbrella. My experience has been mostly with the more disabled end. I can see that the people who are well enough to argue the most are often less disabled, so if they are taken to be the consumer voice that still leaves out a chunk of people who can't advocate for themselves and who need a more paternalistic, best-interest type approach.

**Mr MARTIN** - There has to be a way of looking after both of those groups. You said you don't think you can have two lots of legislation to deal with both groups, but we have to, don't we?

**Dr SCHNEIDER** - I don't honestly think you can because you can't separate them, for instance, by diagnosis. At the moment of coming into a hospital admission involuntarily they are going to look much the same. It is a question of the degree of the recovery they get and how quickly. You need to be able to release people from legislative provisions when they are ready for it, but you need to be able to keep the ones who still need it. One of the problems we have now is that the legislation is already slanted towards the short term. The longest order you can make now is six months in hospital and one year in the community, and that just isn't long enough. On the other hand, it certainly protects those people who are recovering well because their order automatically expires. I think we already have provision for those different levels but it is the more disabled group who are missing out.

**Mr MARTIN** - I can give a case study that I was dealing with last week. It was somebody who doesn't meet the criteria and had fallen through the gap.

**Dr SCHNEIDER** - I have a number of those and I think it is partly the least restrictive alternative stuff that is causing that and partly that everybody is interpreting the provisions we already have in the most minimal way. As I said with the harm provisions, how much harm is harm? Also, the deterioration provision that is already in there I think is a very good provision but people are not that familiar with it. Often the services don't argue it and will tell the family, 'No, this person isn't ill enough. They

won't pass the harm provision, they won't be kept in hospital. There's no point in our trying', and they don't even take them in and test it.

**Mr MARTIN** - That is exactly right. How do you overcome that?

**Dr SCHNEIDER** - I think part of it is staff education. I think that the legislation needs to be tweaked a little bit toward best interest and away from least restrictive.

**CHAIR** - I assume you would have had some involvement in the review of the Mental Health Act?

**Dr SCHNEIDER** - I have had very little involvement in what is currently happening. I don't know the key things that have changed.

**CHAIR** - We haven't even seen a draft bill yet but the consultation has been broadened from what it was going to be originally. It was just going to be minor tweaking with not a lot of change, but then the consultation phase identified a number of areas. So you are not aware of where it is headed or where these concerns of yours may be addressed in that?

**Dr SCHNEIDER** - I am actually not at all aware of it. I know there was a plan about trying to put the treatment provisions into the mental health legislation and I do not know how it is being done or whether in fact it has been done.

**CHAIR** - Going back for a moment to the issue of capacity for someone with a mental health disorder or with a physical health disorder, you said that there were issues around the determination of capacity. Do you want to expand on that a bit in that this is one of the tests of best interest? How does someone appreciate what is in the best interest for them?

**Dr SCHNEIDER** - 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? That argument is generally accepted, for instance, as a ground for implementation of guardianship legislation, which means that a guardianship board or a guardian will make the treatment decisions. That is the way that we have to go at the moment.

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. So the usual loss of capacity is cognitive impairment; in the rest of the world that is what it means. So it is somebody who can no longer determine what their assets are and make reasonable decisions because they do not have the reasoning power. Our patients have the reasoning power in every other respect; their only blind spot is their own illness. So if you are talking about capacity it needs to be very clear that you will include that aspect of capacity.

**CHAIR** - They have to recognise that they have got an illness in the first place.

**Dr SCHNEIDER** - Yes. In fact a lot of the people who argue that they have capacity can certainly sit there and perfectly adequately read lists of side effects of treatment and ask

why would they be subjected to this and can argue very articulately sometimes why they should not be treated, but with the enormous blind spot that they do not see what is being treated.

**CHAIR** - I was having a discussion with a mental health nurse relating a story about a particular patient who is in that exact situation. They wanted him to be placed on an order to be treated because, though he accepted that he had an illness, he did not believe it needed treating. They sent him to be reviewed but he was able to convince the people quite easily that he did not have a problem.

**Dr SCHNEIDER** - One of the key things about that Canadian case that impresses me is that the individual concerned was a very articulate, highly educated person. So cognitively he had it all there. If you talk about capacity it has to be very clear that it includes that broader definition. At the moment the Guardianship Board will accept that but I think that a lot of services are not so articulate themselves in arguing it. It is up to the service to make the case. The Guardianship Board do not make the case; they only adjudicate.

**Mr WILKINSON** - In relation to the States within Australia, who does it the best?

**Dr SCHNEIDER** - I thought you might ask me that and I really do not know. I do not think that Tasmania is necessarily behind. Some of the States where the process is more legalistic are far worse; New South Wales, for example, I would nominate as poor. They have gone down the legal route to the point that a lot of their hearings are actually held in the Magistrates Court instead of in the hospital and things like that with their mental health tribunals, and there is legal representation and all that stuff. Now those things can be seen as advances by some consumer lobbies; I think that they are very backward steps.

**Mr WILKINSON** - What about legislation within this State when a person comes under that legislation and is under treatment then leaves the State for whatever reason?

**Dr SCHNEIDER** - This is a big problem.

**Mr WILKINSON** - That, to me, seems to be a real issue. How can you fix that?

**Dr SCHNEIDER** - 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.

**CHAIR** - Wouldn't you need nationally-consistent legislation to achieve that?

**Dr SCHNEIDER** - If we did that, it would be problematic because some of their legislation is worse than ours and it would take so long to agree. I don't know if it's realistic. In an ideal world we'd have one ideal legislation for the whole country. I don't see why you couldn't have that kind of thing. For instance, there is an interchange of prisoners-type agreement already. It doesn't cover some kinds of legislation that don't exist interstate like, for instance, dangerous criminal legislation here. You can't necessarily transfer

someone interstate on those provisions. They don't have the same set-up in law but for a lot of other things you can. I would have thought that what you'd probably end up doing is, if they're apprehended there they'd end up with a local review under their criteria for the Mental Health Act. That's fair enough; at least they can be apprehended.

**Mr WILKINSON** - That, to me, would solve what is an issue. A couple of people have mentioned to me that once their child leaves the State -

**Dr SCHNEIDER** - Some patients are coming to that and they certainly realise they can leave.

**Mr WILKINSON** - Yes, so one would hope that if a parent or guardian contacted Victoria or whoever it was and said their daughter or son is living in such and such; he was under an order; he now isn't; are you able to assess him or her -

**Dr SCHNEIDER** - The other option, of course, is extradition. If they were just brought back here under our provisions that would solve some problems. The whole question of community orders is a problem anyway in that the enforceability of them is marginal. That is one of the things I think that will be fixed in the review, as everyone's concerned about it. If all you can do is call someone to hospital and they're deteriorating, that's not really what you want; you want to be able to make sure they do have the treatment they are supposed to have in the community so that you prevent a deterioration; that was the whole aim.

**Mr WILKINSON** - Are there any other glaring errors within our legislation that should be fixed?

**Dr SCHNEIDER** - I think we've probably covered the worst ones. There are lots of minor things that come up, but I can't think of them right now.

**Mr WILKINSON** - Are you familiar with other legislation in other States?

**Dr SCHNEIDER** - I've never worked under any of it so it's hard to be really familiar with it.

**Mr WILKINSON** - Yes.

**Dr SCHNEIDER** - I think the other thing that's very murky and, in fact, causes confusion for staff, is emergency treatment. The provisions are different in the forensic system from the general mental health system where, in general, in an emergency you can treat without consent. In the forensic system you can't but there are lots more ways of getting emergency authorisation from the chief forensic psychiatrist. So at least you are sort of double-checking with the next most senior doctor, essentially.

In the emergency situation it doesn't really make much difference which way you go but it would be nice if they were consistent because you have the same consultants covering the roster and two different sectors, and it is confusing. I think they're going towards making the general health sector, mental health sector, analogous so that there will be a chief psychiatrist who has the authority, which I consider to be reasonable.



**Mr WILKINSON** - If we wanted to look at another country and their legislation - and you've mentioned Canada a couple of times - do you think theirs is something that we should look at to get the best outcome?

**Dr SCHNEIDER** - Again, it's not something I know enough about to actually give you a sensible opinion. I do know that there have been constant reviews in Britain, for example, and I am not sure how far they've gone. I think they're still on what I think is too much the rights end of the pendulum. They have a lot of education of their psychiatrists going on at the moment about deprivation of liberty provisions in their Mental Health Act. There was always a problem over there when I worked there 20 years ago, of staff themselves having a libertarian strand. The social workers were often the authorised officers who initiated the request for admission and a lot of them were so pro-patient's rights that they would not do it and the doctors could not initiate the admission. Here I have to say that the professions are probably closer in their approach, which I think is appropriate. At least they are all working together and trying to get people treated. I think setting up those kinds of divisions within professions is not helpful.

So I am sorry, I cannot give you an ideal that I know of.

**Mr DEAN** - You have covered these points here but I just want to inquire a bit further. You are saying in one case that psychiatrists do not want to pursue treatment because of the rights of individuals and so on. The comment here is that psychiatrists find the case too hard to argue or have become too much imbued with the ethos of rights to even try to gain authorisation of treatment, and you have talked about it. So what you are saying there is that there ought to be some relaxation of that. Is that what you are saying, that there needs to be a redefining of that whole thing to give the psychiatrists more opportunity to do what they know needs to be done?

**Dr SCHNEIDER** - Essentially, yes, that would be my view. There is no point in our profession if we cannot treat patients who are not well. That was the trouble.

**Mr DEAN** - That is the issue that was brought to my attention on a number of occasions, that there are patients that are not being given the treatment because of this rights issue. It comes from parents, it comes from family, and they are really concerned about that.

**Dr SCHNEIDER** - Absolutely. For instance, as a psychiatrist, I have seen people in my private practice and sent them into hospital and the hospital psychiatrists have failed in their argument with the tribunal and the patients have been released. I do not know what exactly the hospital psychiatrists said. I had written them a very detailed letter and whether it was used I do not know. I find that kind of thing extremely hard. I am left with nothing I can do for the patient or their family. I do not think those things should happen but I do think that it has become slanted that way, and that is for people who have families who will advocate for them. Obviously, there are a lot more who have not, who were brought in by the police or an ambulance or something and nobody is that interested and they may be let go as well. I think part of it is staff education but part of it is the ethos, which is partly set by the legislation in the terms it is written.

**Mr DEAN** - Another point I had was the level of harm that is necessary to be identified as mental illnesses, which is another issue brought to me by families. What do they have to

do to demonstrate that they will really cause harm? You have given us a recommendation about something that we should consider in looking at that harm level. So what you are saying there is that we need to have a good look at that and to get that right.

**Dr SCHNEIDER** - Yes. I think there is a slight leaning towards if they are not suicidal or homicidal is that really any harm. Not many people are homicidal, actually. It is pretty unusual. They are more likely to maybe trash the place occasionally, cause a nuisance, be very noisy, maybe they start stealing things or doing other slightly antisocial things, which is plenty of harm for most families. The more difficult question is the one that I alluded to before, when they just become very withdrawn and non-functional. To me that is also plenty of harm and if the deterioration provisions were used effectively I think that might cover it, but they do not seem to be.

**Mr DEAN** - The other two issues I had are in relation to admissions. I guess one of the most important issues brought to my attention again is the admission side of it, and whether we have that right. People say they wait around for ages as it takes so long to go through the process of admission. Do you have a view in relation to that?

**Dr SCHNEIDER** - I think this is partly a matter of resources. There have been endless reorganisations of services and it seems to me they are largely because of resource issues. We have had moves between local intakes to services versus one global system of intake, which tends to add yet another layer between the patient and that bed in the ward. One of the most consistent complaints from patients is having to tell their story to three lots of people. It is still very common. I don't think you can eliminate that completely. There are always going to be at least a casualty office or a first-line person and then the staff working on the ward. I think that if you could cut it down to, say, two, it would be quite reasonable.

As to accessibility, they have tried very hard. There is one clear, statewide phone number but it goes to one person in one part of the State. If you happen to be in Burnie, it is usually not someone there. I still think it needs to be more local and that the local hospital services need to be more connected to their local community, not to one statewide number. It was an attempt to save resources by only having to have one person on call at a time for the whole State.

**Mr DEAN** - That was the same position that the police found with rape victims - that they had to tell their story about four or five times in the processes that were set out.

**Dr SCHNEIDER** - I think ease of local access is key.

**CHAIR** - We could be accused of having a bit of a turf war between the legal fraternity and the medical profession. Is this part of the problem? You have made several references to the fact that you don't think there is any place for lawyers in the Medical Health Tribunal.

**Dr SCHNEIDER** - What I am saying is that in the ordinary mental health tribunals I don't think patients should be legally represented. In fact, discussing this with colleagues yesterday, we came up with an interesting idea - and the two people who would have a view on this are sitting there - I think 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.

**Mr MARTIN** - Should they be represented by anyone?

**Dr SCHNEIDER** - I would draw a distinction between advocacy and representation. Somebody sitting there helping them say what they need to say, yes, but I think the person still needs to have an obligation to speak. As I said, the clever lawyer who realises that their client shouldn't speak at all because they will give themselves away would cause a big problem. You can't get away from the tribunals having to some extent to make their own mind up about the person's state of mind, even though that is a medical task and they are legally-orientated. I think it would be fair to say that they have to get some kind of impression of their own.

**CHAIR** - You could accuse a lawyer of not acting in the best interests of the patient in that case. If the lawyer was of a view that if the patient spoke they would reveal the seriousness of their illness and therefore the tribunal would most likely find they need to be detained and treated, if a lawyer said, 'You can't speak because that will happen and I'll get you off' - it would be like getting someone off an offence of which you think they're guilty.

**Dr SCHNEIDER** - The lawyers introduced this 'us and them' thing. They seem to be for their client against all odds a lot of the time. That is not true for all of them. I haven't seen a vast number in action but it does worry me. I do think there is a distinction also between the ordinary mental health tribunals, as I said in my written submission, and the forensic tribunals which are up against much bigger issues. I think those patients often do need legal representation.

**Mr WILKINSON** - So you're saying the best way to deal with them is if the tribunal decides whether they should or shouldn't -

**Dr SCHNEIDER** - The tribunal should have the power to decide if they thought someone was being disadvantaged and needed representation. I think the tribunals make very good decisions.

**CHAIR** - Thank you, Rosemary, for your time and for coming to Hobart to meet with us.

**Dr SCHNEIDER** - I mostly work here at the moment so that is okay.

**THE WITNESS WITHDREW.**

**Ms ANITA JANE SMITH AND Ms DEBRA JANE RIGBY, GUARDIANSHIP AND ADMINISTRATION BOARD AND MENTAL HEALTH TRIBUNAL WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.**

**CHAIR** (Ms Forrest) - Welcome. I know you are aware of the terms of reference of the committee. We are trying to focus particularly on those rather than the broader issues of mental health. We have read your submission so please give us an overview of the main points, particularly where you see the future for this legislation in Tasmania.

**Ms RIGBY** - Given that we heard the previous speaker, I think that there is a dichotomy of view between the medical and legal professions and I do not think there is any hiding that. That view is always reflected in mental health legislation, the tension between the two comes out most dominantly in the legislation itself and that has been an historical thing. If we look at why we have separate mental health legislation, what is it designed to do and what things are necessary for it to achieve, we see that we have separate mental health legislation from an historical perspective. We have it because it was introduced to do something different to guardianship originally and we have just continued with the system, but if you go to the basics of it it is discriminatory. The act very clearly states in the beginning, that mental health patients should not be discriminated against or treated any differently to physically ill people, but the very fact that we have an act that only deals with mental health patients is in itself discriminatory. We are treating people differently from the physically ill because we have that act.

We have an act that is based on dangerousness and risk. We do not use those terms in relation to physical illness at all. In dealing with a physical illness we focus on the person, how can we make them well and how can we assist them with the deficit that they might have. In treating a mental illness we look at this dangerousness and risk which is insulting to the patients, frankly.

**CHAIR** - You are making the assumption that because of the mental illness there is an element of risk and danger, automatically because of the way the legislation is framed.

**Ms RIGBY** - Yes, that is right.

**Ms SMITH** - The legislation reinforces that.

**Ms RIGBY** - What happens in tribunals is that patients are insulted because the treating team talks about risks to others or risk to self. Now the patient will sit there and tell you, 'I am a good person. I have never hurt anybody. I would never hurt anybody. I am not violent'. That is their response to that criterion. They very much feel that they are being classified as a person who is a danger to others. I wonder whether that criterion is necessary to achieve the aim of getting treatment for people who require treatment. Do we need to talk about risk and dangerousness? We do not talk about it in relation to anybody else. If you went into petty sessions on any given day you would see more dangerous people and more potential for danger - and we are just talking about a potential. These people do not need to have done anything; it is just the fact that they may do something in the future. There is more potential for danger in the general community than there is in the DPM.

**CHAIR** - I have read some of the research that would suggest that to be the case, but then how do you deal with people under the influence of ice or something like that where you have a psychotic episode and do harm people, property, other persons and that sort of thing? How do we deal with them under a framework that does not discriminate?

**Ms SMITH** - I think that is a question for the criminal law really. Your response to a criminal act is different to the work of the tribunals that we are talking about here - the Mental Health Tribunal or the Guardianship and Administration Board. The fact that people, while unhinged mentally, might commit different acts from what they would if they were well is something that we have to take into account. As one of the examples in our paper says there are ways that people physical illnesses might cause harm as well. That is not the subject of any particular piece of legislation.

**Mr DEAN** - Are you saying that we need to wait for a criminal act to occur for that assessment to be made?

**Ms SMITH** - No. Perhaps to come back to a more basic level, what we are saying is that these pieces of legislation are now more than 10 years old. A number of really significant things have happened in that 10 years. For instance, the Burdekin report was released from the Human Rights and Equal Opportunity Commission and it told us a lot about mental illness that was not part of the fabric before. We have seen the operation of these two acts and there have also been a lot of developments in community understanding of mental illness and also in the drug regimes available. The past 10 years have really seen quite a revolution in mental health and yet the legislation that we have reflects quite a different legislative framework.

One of the things that has happened in that 10 years is that it is no longer seen as an appropriate response to mental illness to simply lock them up in hospital and treat them against their will. There is a whole range of other much more holistic support that needs to be put in place that prevents them getting to the stage of being a risk to themselves and others. So to have a piece of legislation that only deals with them once they are at the stage of being a risk to themselves and others is letting that group of people in our community down. That is interesting because, in the 10 years of guardianship administration, we have seen that guardianship administration orders can provide some of those other supports. Using our best-interests and capacity model they can provide those supports that mean that you do not get to the stage of assessing whether someone creates a risk to themselves or others. It is looking at whether that scheme of assessing capacity and best interests could eventually take over the range of those decisions that need to be made on behalf of the people who cannot make decisions for themselves, or do you still need a separate body of legislation that deals with a very specific point in time in a person's mental illness? Our argument in the paper was that if you set up a range of options, like guardianship administration but calling them new names and having a new legislative scheme, would it mean that you can admit someone to hospital earlier if you are admitting them in their best interests as opposed to admitting them because they are creating a significant risk to themselves or others.

**CHAIR** - Are you suggesting that a combination or bringing together of the guardianship administration roles into what is a separate act from the Mental Health Act and taking over some of those, or intervening earlier, and having that role where the patient's best interests are considered earlier rather than later, is the way forward?

**Ms SMITH** - To some extent it already happens. Over a quarter of people who come before the Guardianship and Administration Board have always been people with a defined mental illness but they do not necessarily reach the test of being a person for whom the Mental Health Act would apply. For instance, for someone who has bipolar affective disorder and is in the stages of mania that very often has a financial impact for them because they go on a spending spree thinking that they have a lot more resources than they in fact have. The impact of that can be that they end up with very significant debts which hinder their recovery once the mania is over and also contribute to their depression because now I have not only a mental illness but also a very significant debt. The ability to make an administration order which puts somebody else in control of their funds to prevent the spending spree is a positive and holistic response to mental illness. So we have been doing those sorts of things already.

It is not so much about guardianship subsuming mental health legislation but rather creating a new system that focuses on capacity - or lack of capacity for whatever reason, be it addiction or compulsion or a disability - and on the best interest of the person, taking into account their wishes and a less restrictive alternative. So it is about taking the best of both systems and creating a new system.

**Mr MARTIN** - This is a really key issue for me; how do you come up with a legal definition of 'best interest'?

**Ms SMITH** - It is not defined and I think that is a good thing. It is up to the tribunal or board members to determine best interests and the way that presents in every single case is different. We are multidisciplinary boards, so often we sit with a social worker, medico, accountant or lawyer. There are three of us and there might be any mix of people who would sit. Three heads are so much better than one, particularly when they come from different disciplines. The way that we think of best interests can be a really holistic look at it, but as I say, it is different for every single person. For some people, being hospitalised and treated against their will be in their best interests, but you might look at the period of hospitalisation or the type of drugs. Some people have particular aversions to injections, which are a favoured form of medication these days for antipsychotic medications. If someone has a particular phobia it is only going to do more harm to them to be given that sort of treatment. So best interest can be talking about types of treatment or the length of detention rather than whether or not it is there. So I think it is good that it remains undefined because it enables the tribunals to give a very human approach to what is in the best interests.

**Mr MARTIN** - Would the decisions be different if one of the three people making the decision were changed?

**Ms SMITH** - There are in fact criteria for treatment that define best interest. We have to take into account the wishes of the person, the effect of not treating them, any side effects or any alternative drugs, whether treatment could be delayed so the person might obtain the capacity to give consent to that treatment. Best interest in terms of treatment has been broken down but in relation to things like appointing a guardian or appointing an administrator it is usually that we have to take into account the best interests of the patient. It is an underlying principle in any decision that we make as well as any

decision a guardian or an administrator has to make. As we have said in the paper, the principles remain very strong and I think the way that they interact is very good as well.

**Ms RIGBY** - In the Mental Health Act as it currently stands the best interests of the patient is not one of our criteria.

**CHAIR** - So with the review of the Mental Health Act, you have obviously been involved in that, and the intent of this committee is not to stymie that in any way but to look to the future and what is in the best interests of everybody, so are these some of the things that are being addressed in the review?

**Ms RIGBY** - I do not think the current drafts have mentioned best interests. I do not think it has any higher place in the draft that we are getting through at the moment than it has in the current legislation. But there are reforms in the act, like earlier review and those sorts of reforms are in the best interests of the patient. They will make improvements but I guess what we are saying is that the review that is currently under way is dealing solely with the Mental Health Act and, from our point of view, that is not an appropriate approach. The approach should have been to look at the Guardianship and Administration Act and the Mental Health Act combined.

**Mr DEAN** - What about the Alcohol and Drug Dependency Act?

**Ms RIGBY** - And the Alcohol and Drug Dependency Act because they all deal with similar issues but they come from different perspectives and they apply different tests. We need to ask, is that an appropriate way?

**Ms SMITH** - With the legislation, the interaction between the Guardianship and Administration Act and the Mental Health Act, even though they were passed one year apart, the interaction between them is a very complex area. Over the period since my appointment - and I am in my seventh year now - most of the requests for advice we have had to put forward to the Solicitor-General's Office have been about working out the interaction between these two acts. Taking into account that the Guardianship and Administration Act covers a much broader territory, many different disabilities and more outcomes from an application, it is interesting that it has generated that level of interest in the interaction between the two acts.

With the current round of reviews of the Mental Health Act my concern was that while the proposals would probably make the system better, but the question is whether we are looking to make the system better or whether it would be more appropriate to make a better system. Perhaps it is not about just amending what we have and taking it for granted that we need a Mental Health Act but taking a step back and saying, 'Why do we have a Mental Health Act? Why is there an Alcohol and Drug Dependency Act that nobody uses? Why do we have a separate sphere and set these people out with their own little piece of legislation when everyone could benefit from a capacity and best interest model that is limited in time, that is purpose-specific to what that person needs and is able to -

**CHAIR** - What would you call that legislation? You cannot call it a mental health act because then it would immediately be discriminating against a sector of the community with mental health disorders.

**Ms SMITH** - In Ontario, I think it is, they called it consent and capacity legislation, which covers the field somewhat. You could simply call it 'incapacity legislation' but that is a matter for parliamentary draftspersons and I will not even go down that track.

**CHAIR** - Do we try to encompass in a system like that all the physical health stuff?

**Ms SMITH** - To an extent with the Guardianship and Administration Board some of the people who have been subject to orders and applications have cerebral palsy, which is essentially a physical disability but it can in certain circumstances have effects on capacity and a range of disabilities that begin as a physical disability and may end up having cognitive effects. It is not unusual for us to take into account a really broad range of disabilities.

**CHAIR** - Is there somewhere, either within Australia or around the world, that uses a system such as you propose that we should look at? One that seems to be working or is not working, whatever the case may be.

**Ms SMITH** - There are places like Ontario that have a consent and capacity board but we found in our research that they still tend to have a separate mental health stream. The only one that I am aware of that has completely abolished mental health legislation is Yukon in Canada. They did it for very similar reasons to what is proposed in this range of papers here. I think I forwarded a paper to you, Madam Chair, from Robert Gordon.

**CHAIR** - I received it today. It has been sitting on my desk since November.

**Ms SMITH** - That would be the only place that I am aware of, within an English legal system, that has completely abolished that mental health stream.

**CHAIR** - Do you know what led to that?

**Ms SMITH** - This same sort of discussion. It is about 10 years ago, so it happened quite some time ago. He raised that same level of concern that Dr Rosenman and Terry Carney have raised and we have quoted. The Yukon government decided that was interesting; and it is interesting that this is also a small community. In a small community sometimes you can merge facilities and resources in a way that a larger community can't. There might be the same opportunity in Tasmania to make amendments that others haven't managed, because we have a small population and the interconnectedness already exists between the board and the tribunal.

**CHAIR** - On the issue of family involvement, I've heard, in the public arena as well as through submissions and my experience in working in health, that families of the person suffering from mental illness have varying views on this. Some feel that they don't want to make the decisions because that would make them the nasty person who put them in hospital or they're the tyrant who does terrible things to them when they're discharged and things like that. They claim not to be while the person suffering the mental illness claims that they definitely did. There are family members who say they don't get enough information; their son, daughter, husband or wife is admitted to hospital and they know nothing about what's going on because the mentally ill person said there was to be no communication with my mother, father or whoever. In a framework that you're talking



about, how do we deal with these issues where ideally we want families to be able to remain a cohesive unit and not have the divisions that seem to be happening in a number of cases?

**Ms SMITH** - In our paper we've suggested that we would replace the role of the person called a guardian, with one called a capacity agent. It sounds a bit clumsy and if someone comes up with a better term we would like that. At the moment, when the board is appointing a guardian first, we have to be satisfied a person has a disability; and second, that the disability affects their capacity to make reasonable judgments and, third, that there are judgments or decisions that need to be made. Then when we look at the appropriateness of the guardian one of the things we have to take into account in Section 21 is the desirability of preserving family relationships.

That cuts two ways according to the family. It can either be that appointing a family member as a guardian will preserve family relationships or it might be that appointing an independent person, who can take the blame and the flak that you're talking about, might preserve family relationships. It's a really good test because it makes you think about family relationships. Legislation has recognised that they're a preventive and restorative force for people with mental illnesses and we need to preserve them but there are two ways to preserve them. One is to put the contentious decisions in the hands of an independent person and the other is to give the family that control. It really depends on the individual and the circumstances and we make that decision in the best interests of the person.

**CHAIR** - There's often a varying view about what's in the best interests of the person from the family's perspective because they don't feel they're getting any information about what's happening with their family members in hospital. How does that fit in and work?

**Ms SMITH** - Guardians do play a really important role in being a conduit for information. The guardian has the authority to make the decision about whether to share information, whereas health professionals can be bound by their professional code. The guardian is enforced to make decisions about how much information needs to be shared. There are certainly some families who can be a destructive force in the life of a person with a disability and the guardian or administrator, for instance, might choose not to disclose financial details or other personal details about that person if it's going to protect the safety of the person or their assets. There are other families who are desperate for information and a guardian, if they have that information, would be able to assist in protecting and promoting the wellbeing of the person. The guardian can make those choices. I suspect that in an agency system that would be the same.

**Ms RIGBY** - Certainly, in the current legislation, families frequently ring the tribunal and say they've been sent a notice, they'd like to tell us what we want to know but they cannot come to the hearing because if they say this in front of their family member that would cause problems when that person is discharged into the care of the family.

**Ms SMITH** - I've had situations in hearings, particularly hearings at the hospital for people being treated for mental illness, where family members have come and heard for the first time what their young adult son or daughter has been diagnosed with, what the treatment is and what the likely prospects are. So since the time of 16 and 17 they haven't been able to access that medical information but they come to a hearing because it is a public

hearing and they get access to that information and get to ask questions of the practitioners that couldn't in any other forum. Sometimes it is the very example of what we call 'therapeutic jurisprudence', that that isn't able to happen. Sometimes the patients themselves say, 'I don't want them here' and we need to receive their information in separate hearings or something like that, but we encourage family members to be present if they feel they are able to.

**CHAIR** - So when a patient says, 'I don't want them here', who makes the decision prior to the hearing?

**Ms SMITH** - The board or the tribunal, or at the time the application is raised. Sometimes it might happen part-way through if a family member starts saying something they find offensive - and they can sometimes say offensive things, wanting the tribunal desperately to know some things about how hard their life has been - and the person might then say, 'I want them out'. Again, it is an individualised thing and you have to work out whether hearing any more information from that person is going to benefit the decision the board or tribunal has to make.

**Mr WILKINSON** - Could I ask about a situation in relation to when orders are made, people leave the jurisdiction, go to Victoria or wherever it might be, and no orders are binding, are they, on that person when they are outside the State?

**Ms SMITH** - Guardianship and administration orders can simply be registered in the corresponding States and take effect as if they are there.

**Ms RIGBY** - Mental health orders don't go from State to State and one of the reasons for that is that every State has a different test; every State applies different criteria. What would be sufficient to have you placed on an order in Tasmania may not be sufficient to have you placed on order in Victoria.

**Mr WILKINSON** - To me that seems ridiculous. What is the best way to solve it?

**Ms RIGBY** - There have been discussions for years about having a system throughout Australia with the same criteria but it doesn't seem to get anywhere.

**Mr DEAN** - Is the current review that is being done on the Mental Health Act touching on that point, do you know?

**Ms RIGBY** - It needs the agreement of all the other States for us to get anywhere with that. Whilst we have signed up for recognition, a lot of the States haven't. It is particularly ridiculous if you happen to live in Albury; you can move in and out of the jurisdiction. If you're put on an order in Victoria, you just go across the border.

**Ms SMITH** - Are we nearly done, or I do need to ask to go in camera?

**CHAIR** - We don't have much more. Could you give a summary of your view of the ideal world so far as the future for mental health services is concerned? I know that we are restricted in that we don't have a nationally-consistent legislative framework here, and in view of the fact that Tasmania is currently getting towards the end of a review of the current Mental Health Act - I don't want to see that railroad in any way, but we also

need to look at what is in the best interests of everyone in the future - but could you put into a nutshell what you believe should be the way forward, in spite of the changes that may or may not be made in the review of the Mental Health Act? What would you suggest?

**Ms RIGBY** - I would certainly hope that we can get some changes, that the review goes ahead, because we need change now. Looking into the future, I would hope that we would have a review of the three acts together - a combined review - looking at a system that deals with all persons with a disability, be it physical or mental, applying the same criteria to those persons, and applying the same tribunal and process to those persons. That is what I would ideally have.

**CHAIR** - With regard to people with a physical illness, we have had well-publicised cases in the past of women who were pregnant and who have had two or three previous Caesareans and are maybe carrying twins or a single-term pregnancy and who refuse to have a Caesarean and will labour at home if they need to to achieve that. We know there is quite a significant element of risk in that. Women have then sometimes had their rights taken away and the Caesarean has been done or they may or may not end up in hospital or whatever. Do we need to encompass those decision-making frameworks regarding all health issues under this one body?

**Ms RIGBY** - Yes.

**Ms SMITH** - Related to their capacity to make that decision whether the capacity is undermined by an addiction or compulsion or disability. I think if the person has capacity then they have rights to make those decisions. But if that capacity is undermined by delusion or a mistaken belief, I guess that might be something that could come into this legislation.

**CHAIR** - I guess in that situation that is why there is another person involved too, which is a little bit different.

**Ms SMITH** - I think that the legal situation has been that Child Protection and those sorts of agencies cannot become involved until the child is born so while the child is *in utero* there is not protection.

**CHAIR** - That is an issue too.

**Ms SMITH** - I think that is probably slightly outside of the framework that we are looking at.

**Mr DEAN** - You have just touched on the review you are saying should occur in relation to all the three acts together. Has there been a submission made to the current review of the Mental Health Act along those lines? If not, do we have to wait until 12 years for that to occur because the current act has now been in place since 1996. So do we have to wait another 11 or 12 years for that to occur?

**Ms RIGBY** - The submission has gone in.

**Mr DEAN** - What feedback have you had?

**Ms SMITH** - I made two submissions, or maybe even three, along these lines in the last two years but the response has been that the Mental Health Act review was too far down the track to take on such a large framework as I am proposing. Also there is a difference in the administrative arrangements so the Mental Health Act in part relates to the Health Department but part of it is under Justice Department and all of the Guardianship and Administration Act is under the Justice Department. So we need the will of, now, one minister, but it was at that time two, and two departments. I would hope that we would be looking a four to five-year time frame for these three acts to be considered together and for a unified outcome that would mean that families just go to one place to get the advice that they need and just go to one place to get the orders they need.

**Mr DEAN** - It is not a reasonable or acceptable argument, is it, the fact that it falls under several different jurisdictions for it not to occur.

**Ms SMITH** - It would be a political question and I would leave that to you.

**CHAIR** - There has been no commitment at this stage to undertake that review that you are aware of? We will ask the question too.

**Ms SMITH** - No, I guess those people will be coming to the committee hearings.

**Ms RIGBY** - On the one hand I do not want to hold up what are necessary amendments but on the other hand I can see that we then get an amended Mental Health Act and discussion stops because we are told that we have just done that so we are not looking at that again, so that the discussion that would involve the three pieces of legislation together stops. That is my real concern.

**Mr MARTIN** - That is likely, isn't it.

**Ms RIGBY** - Yes.

**Ms SMITH** - As I said earlier, it is one thing to look at making the system better but it would be another thing altogether to look at making a better system, and I think the merging of all three pieces of legislation creates the better system.

**Mr MARTIN** - If the current review happens to be implemented and the legislation changed so that it meant dividing the review of all three, what do you think?

**Ms SMITH** - To be fair, I think that the minister has always said it is an interesting idea but it is just the wrong time. I am hoping that that means that down the track there may be a commitment to looking at all three pieces of legislation together.

**CHAIR** - There is broad support for the review of the Mental Health Act and the need for change. That has been identified by pretty much everybody in the field, I would suggest. That needs to continue and be completed but it is not an excuse to put the rest on hold. That is what you are suggesting. Because the Drug and Alcohol Dependency Act is not used and so far out of date, that it clearly needs it, but also the Guardianship and Administration Act has not been reviewed for a number of years.

**Ms SMITH** - Same time frame as the Mental Health Act. I think it is working fine but certainly there are some improvements that could be made, particularly in that area I mentioned before about the difficulty of the relationship between the two pieces of legislation - guardianship and mental health. That does cause concerns on a frequent basis.

**CHAIR** - Do you believe there is the risk that, because there are those blurred boundaries and uncertainties between the two acts, people actually can fall through the gap?

**Ms SMITH** - Guardianship legislation is broader than mental health but I think that right now there are people who do fall between the gaps. The medical profession can be given one set of advice about this person who does not fit the Mental Health Act criteria and then there are questions about whether the guardian can enforce powers that might otherwise be enforced under the Mental Health Act. So there are definitely people today at risk from that gap.

**CHAIR** - So an act, such as a capacity and consent act, that would be inclusive of all people would help go some way to preventing that?

**Ms SMITH** - It would be like a doubts removal act because you do not have the tension and the interaction between the two pieces of legislation. You just have one piece of legislation; it means medical professionals get advice from one piece of legislation. You have a comprehensive scheme.

**Ms RIGBY** - Clinicians are definitely extremely confused and they make comments like, 'You expect us to be lawyers as well. How do we know which act to go to and how do we know how they interact?'. It is very confusing.

**Mr MARTIN** - Is there a way in which we can do something with it now without an all-encompassing review?

**Ms SMITH** - I have had education schemes for medical practitioners in almost every year since I have started. The ability for medical practitioners to leave their clinical duties, particularly in the psychiatric area, and come to a two- or three-hour training session on the very complex area of law is limited. Attendance - even if I put them out of hours - at those sessions has been very limited. There just is not the time to go into the detail. It is a very complex area.

**Ms RIGBY** - Again I provide training on the Mental Health Act. We get lots of case managers and lots of nursing staff along but the doctors find that there is just not the resourcing for them to do this. Also they find it very difficult. They became doctors; they did not become lawyers. They find this very complex.

**CHAIR** - Thank you very much. We will draw it to a close there.

**THE WITNESSES WITHDREW.**

**Mr KENNETH JOHN HARDAKER AND Ms VALERIE ANNE WILLIAMS,  
ADVOCACY TASMANIA INC, WERE CALLED, MADE THE STATUTORY  
DECLARATION AND WERE EXAMINED.**

**CHAIR** - Thank you for coming along.

**Mr HARDAKER** - We note the term of reference on the role and function of protective legislative schemes with respect to promoting the rights and protecting the wellbeing of people with psychiatric disabilities and or addictions. This is a term of reference that is particularly relevant to our organisation. We see the role of advocacy being primarily about helping to protect the rights and interests of vulnerable citizens and we are very interested in the inquiry.

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 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. In our submission we have highlighted what we think are some of the deficiencies in our current system and current legislation. We believe that this inquiry creates the opportunity to correct some of those current problems and strengthen those things that are working reasonably well.

So we have highlighted a number of things. We have highlighted the issue of capacity and a person's right to refuse treatment, a matter that we think needs more debate. We have talked about the current safeguards, particularly official visitors and the Mental Health Tribunal and what we think are some of the weaknesses there. Regarding the need for a greater role of independent advocacy, we have mentioned the independent mental capacity advocates which are now in existence in the UK and the role that they perform.

With the need for better systems oversight, we referred specifically to the Mental Health Tribunal but we equally could have discussed the sorts of systems that exist in some other States, such as the public advocate role which we do not have here. In some jurisdictions there are mental health commissions with a systems oversight role. We have also referred to the UN Convention on the Rights of People with Disabilities, which Australia has recently ratified. We think that has implications for this process and the need to test all Australian and Tasmanian legislation against that convention.

In conclusion we would say that the review of the current Mental Health Act, which commenced prior to this inquiry, has reached the stage where it has been stalled for some time now. Our observations are that there is a strong medical model or medical orientation to the sorts of changes that may be proposed and we would like to see much more emphasis on human rights. We think overall that the debate both nationally and internationally has shifted and there is a much stronger emphasis on peoples' rights nowadays, a lot more discussion around charters of rights and that sort of thing, plus the UN convention allied with that.

We also note that governments of all persuasions are struggling financially to have the money to fund things such as new acts. So we believe that if we were just to proceed

with the review as it is we may find ourselves with a new act but no means by which to implement it, so it would sit there for some time before anything happened. I think the previous act sat there for three years before it was implemented. We may find ourselves with the same situation again so that creates an opportunity to do the sort of process that Anita Smith and Debra Rigby were talking about - reviewing the totality of those acts that are all interconnected and looking at issues around capacity. By doing that and also looking at the UN convention and how that affects all of our legislation we might end up with a much better system overall.

**CHAIR** - Are you suggesting that there should be a move to basically ignore the Mental Health Act review? Do you think that should proceed? We are told that it is going to be presented at this sitting of parliament but you obviously support a comprehensive review of the three acts, particularly in line with the UN convention that was recently ratified. Can you just clarify that for me?

**Mr HARDAKER** - If we just proceed with a review as is currently happening we will get through that process and we will have a bill and a new act and then it will sit there for two or three years because the Government will not be in a position to fund a range of things that the new act is likely to require. Just picking one thing, there is the notion of having a chief psychiatrist. That is going to cost money. You are not going to be able to set up an office of the chief psychiatrist for nothing. There will be a range of costs associated with implementing the legislation so it may well sit there for who knows how long. I guess nobody knows at this stage how long it will take for global economic conditions to change, in which case there is an argument that says why couldn't we roll that review in with reviews of the Guardianship Act and the Drug and Alcohol Act and other associated legislation, too. We also need to look at the Disability Services Act because that is also affected by the UN conventions. Even though it is proposing a bigger process there seems to be a window of opportunity to do that now that we could take advantage of.

**CHAIR** - Are you suggesting that even if a new bill were presented and passed so that it became an act it would not be proclaimed for some time because of the economic constraints and that if that was likely to be the outcome it would be better to put it on hold altogether and just do the comprehensive review?

**Mr HARDAKER** - We believe so.

**Mr DEAN** - Could I ask you why you believe that?

**Ms WILLIAMS** - It is the process that we followed to get to a bill. We had two weeks. There was community consultation for two weeks once the issues paper was tabled by the department, so the community had two weeks to comment on that. We fought to get the time extended so that we ended up a period of four weeks. The process has been so rushed and is still being rushed and I would certainly argue that the consultation has not been broad enough. When you are dealing with the community sector we are so under-resourced, so under-funded and to a great extent so under-skilled that you get a huge issues paper - and I think that that was 100 pages, from memory - and it is sent to very small community organisations that may have one paid worker and a handful of volunteers and it is quite legalistic and philosophical. There are huge areas of concern

that require legal debate and these people do not have the resources to adequately, if at all, respond to this.

We have had a process that has been medically led. We have not had legal involvement. If you look at the process in the ACT you will see that the review of their act it took two years and the list of people involved was very extensive, including clinical and legal people because we are talking about legislation. This is complex legislation and yet we do not have any real legal involvement in getting this bill ready.

**Mr DEAN** - Do you believe that we could get a new bill that has taken into account the costs of implementation of it, and then not get the best position for mental health moving forward? In other words, it would impact on the way the new bill is written and what it requires. Is that a risk?

**Ms WILLIAMS** - I think there are lots of risks and I think we have tried to identify some of those risks but that is one real risk. There is also a huge movement in the human rights area, particularly with the European Court of Human Rights that is coming with these legal decisions 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. When you look at the act itself, it 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. There are lots of issues around changes that are happening so when we do get a bill and it sits there, in that corresponding period so many changes can happen so that once we actually implement the bill one of the risks is the bill will be dated or the act will be dated at the time of implementation because the world will have moved forward in its understanding of human rights.

**Mr MARTIN** - I think you're saying that you don't have any confidence in the current review, that you'd rather see nothing implemented until the all-encompassing review of the three acts at once. Is that right?

**Mr HARDAKER** - It's difficult to know for certain until we officially see a bill released, which we haven't seen yet. We've only had a discussion process and there've been two phases of that; I think it was a discussion paper followed by an options paper. So until we see that next step, which is a draft bill, we don't know for certain. We have been involved on the advisory group that is part of the process so we have, I guess, some inside involvement from that point of view, which I guess we're not permitted to really talk too much about but certainly the process has been very much led by the drafting committee which is very much a medical group; these are clinicians who are doing the drafting of the legislation. We're not saying that some of those people don't have very strong or positive views on human rights but it is very dominated by a medical perspective. We don't believe that the advisory group, where there is a slightly broader range of perspectives, has a very strong voice in that process. As Valerie was saying, it's still a very narrow process anyway. We can't be definitive until we see that draft but we have felt that overall the process has been very much dominated by a medical perspective.



**CHAIR** - You did make a comment in the submission here that, unlike the review of the 1963 act, the present review is being driven by doctors and nurses in mental health services. I pose the question; is that an issue here? Are we actually looking at a turf war between the lawyers and the doctors or medical staff? Why isn't that appropriate?

**Ms WILLIAMS** - I wouldn't say that there's a turf war when you don't have the lawyers involved in it. Maybe we need a turf war when we're talking about legislation. I was involved in the review of the 1963 act and the implementation of the 1996 act. That process took many years and was actually led by government and it was a response to the medical model 1963 act where, at that stage, the *Sunday Mercury* led every week with photos of Royal Derwent and Willow Court and the atrocities that were occurring out there. The Government actually led that and we still have the discussion papers that it produced saying that we need to go to a human rights model and we need to get away from the medical model where the doctors make these decisions and these decisions are not tested.

We ended up with the 1996 act. In many respects it's a very good rights-focused act. It does have some problems. We had a process of implementation review and we were involved in that and our first submission was in 1999, about the responsible person and the problems associated with that. That process never followed through. So, in actual fact, we'd never looked at the 1996 act as part of an implementation process; identified what things were wrong and what things needed to be fixed, which is a normal part of a major piece of legislation. It was intended; it just wasn't followed through and, again, the issue was money.

**CHAIR** - It was supposed to be done within 12 months.

**Ms WILLIAMS** - The process did start and I addressed the implementation committee but it fell down and it changed and, through the period, it developed into, 'well, let's review the whole act.' So, we've not had that implementation review of the present act. In the time, we've moved away from the problems that triggered the review of the 1963 act. We don't have those kinds of problems anymore. We do have other problems but we don't have that front page *Mercury*, kids in pyjamas all day, tied, chained to walls, which was happening in those days. If anybody ever asked me, I would say, 'It would be really nice if we did what we said we were going to do and were required to do, which is to review the implementation of the act'. But it didn't happen and now we are in a review of the entire act and looking at repealing the act. That is okay if you have appropriate consultation with the community over a proper period of time, with the appropriate levels of people debating complex issues around mental illness and the rights of people, their autonomy et cetera.

**Mr MARTIN** - People say that doesn't happen.

**Ms WILLIAMS** - No. That is what I would say.

**Mr MARTIN** - It is very deficient in that regard.

**Ms WILLIAMS** - Absolutely.

**CHAIR** - You make some fairly detailed criticisms in regard to the Guardianship and Administration Act as well. We have had evidence that there is a belief that the Guardianship and Administration Act is working quite well but that there is room for improvement. Do you have a different view of that?

**Ms WILLIAMS** - It is a piece of law and we follow the law that we have but, for example, if you look at the Guardianship and Administration Act it is divided into three sections: treatment, guardianship and financial administration. There are different criteria for those three areas - the first one, which is treatment, is capacity. That is medical law; that is accepted worldwide as a person has the right to decide their own medical treatment unless they lack capacity. When we get to the guardianship and administration we are not looking at capacity, we are looking at best interest and people making decisions that other people don't like. That affects only people who have disabilities. I always use the example that I have children in their early 20s and went through their teenage years. All of my children have made decisions that were wrong and I couldn't change but they were legally able to make those decisions, no matter how unreasonable, how bad or whatever. Because they didn't have a disability you don't get the Guardianship and Administration Board involved. That is the difference.

If you look at, for example, testamentary capacity, where people can make wills, the wills can be horrendous and leave no money to their children but as long as they satisfy the capacity test they can do that. It comes down to, 'You have a disability, but do you lack capacity? Are you making a decision based on your lack of capacity? Do you not understand the nature and effect' et cetera. We have a piece of legislation and it has a legal test. The legal test for guardianship and administration in the Guardianship and Administration Act doesn't match the legal test for treatment and that is because we have a whole area of medical treatment law that you can't just ignore.

I believe that there needs to be debate because in other jurisdictions, such as Ontario, you have capacity boards. There is the Mental Capacity Act in the UK, which is based on whether a person with a disability has capacity or not. If they don't have capacity, that is when the board becomes involved in the Court of Protection, which effectively is the same as the Guardianship and Administration Board. The issue there is capacity.

**CHAIR** - Do we need to better define 'capacity'?

**Ms WILLIAMS** - I don't know that we need to define it. 'Capacity' has a very clear definition but we just don't use it in the Guardianship and Administration Act, except in the area of treatment. We don't use it for guardianship or administration. Should we? That is what needs to be debated. These are serious questions when you are taking away the rights of human being.

I will give you an example around administration, the Public Trust officer coming in. I am the mental health advocate, and probably 70 per cent of my clients would have administration orders because one of the first things that happens when they are admitted to hospital is that an application is made for an administration order. It has nothing to do with the person lacking capacity, it is a way of supporting them to live better or guarantee that certain things are paid. For many of these people it becomes a very harsh burden because they have to pay Public Trust Office fees. When most of us pay our bills we tend to pinch from Peter to pay Paul. We may have a Hydro bill so we put all our

resources into paying that and then the next week or fortnight we pay our telephone bill, whereas when you have somebody managing your money they are taking out a set amount all the time. A lot of people who are on disability pensions, for example, do not save. When you have the trust officer managing their affairs, they take out a proportion to save. I am not saying that is good and I am not saying that is bad. I am saying it is very burdensome on people living on a disability pension. The question I would be asking is when is it appropriate for the State to put that burden on somebody?

**Mr MARTIN** - What is your answer to that?

**Ms WILLIAMS** - I think it needs to be debated. I think it needs to be questioned as to whether it is when they are incapable or are they just bad managers? There are a lot of people who are bad managers of their money.

**Mr WILKINSON** - Should it be left to the Guardianship and Administration Board if they are bad managers, especially if they have an illness? That could exacerbate the illness that they have by accumulating debts which they cannot cope with. It is a difficult area, because where do we start, where do we stop?

**Ms WILLIAMS** - That is why we need to be debating the area because it is difficult and that that is what I am trying to say.

**Mr WILKINSON** - Should it be left to the board to decide whether a person has this capacity?

**Ms WILLIAMS** - I would say that you start at the beginning. Who is eligible to apply to appear before the board? How do you determine whether Joe or Mary or Peter should have an application made that is taken to the board? Just the process of going through that is difficult in itself.

**CHAIR** - Do you think a comprehensive review of the four acts, including the Disability Services Act, would stimulate the sort of debate that you say needs to be had?

**Ms WILLIAMS** - I would think so. If there was a proper amount of time given to it and we looked at other jurisdictions, such as the UK, Canada, even New Zealand and other States because there is a whole trend, a movement. It is not that our organisation has decided to look at various other jurisdictions in a vacuum.

**CHAIR** - Is there is one jurisdiction, or more than one, that stands out as perhaps being the leading light in this or is it such a hotchpotch that it is hard to know where to look?

**Ms WILLIAMS** - I would say it is a hotchpotch. The thing with the UK is they are bound by the European Court of Human Rights. That court makes decisions and they are then legally obliged to incorporate those decisions into their legislation. However, they have a mental health act as well. They do also have a human rights act, but they have a mental health act where there is no mention of capacity in that jurisdiction. If you are placed on a mental health order and you go into one of the psychiatric hospitals, as a matter of right you are just treated.

It is not an issue that would go to the tribunal or the board in Tasmania's case because if you want to involuntarily treat in this State you have to get that permission from the Guardianship Board.

Tasmania actually leads the world in some areas compared to other jurisdictions in Australia. There are only two ways in the Mental Health Act that a person can be treated and that is with their consent or through an order of the Guardianship Board.

In other jurisdictions, once they put you into hospital they can do anything they like to you. So from a human rights perspective that is acknowledging a person's rights and it has to go to a review. As you say, Jim, with the Guardianship Board they then debate whether that person should be treated and at the end of that you come out with an independently reviewed decision rather than going in and a doctor saying 'I want to treat you with this and it does not matter what anybody says, and with this amount'. You have that independent review so there are some good things.

**Mr DEAN** - What you are telling us has been in your submission to the authorities that have been doing the review of the Mental Health Act, I take it?

**Ms WILLIAMS** - Yes.

**Mr DEAN** - And if that is so, is there anything that has been said to you to suggest that some of those issues, if not all have not been considered in the current review?

**Ms WILLIAMS** - We have been very involved with the review right from the start, we are on the advisory group. When the issues paper was written and distributed to the community sector with two weeks to comment, and it was a very large, complicated document, my organisation gave me two weeks off, virtually, to write the review. I wrote quite an extensive 80-page comment to the document.

I then e-mailed it out to every organisation including TasCOSS, Anglicare et cetera. Then they used that document as a basis to formulate their own submissions. Some were only one page long but they looked at the issues that were raised in the larger document. The result from that was a resounding 'we need more safeguards'. They all wanted more safeguards because the act is an act to safeguard the rights of people.

We do not have a bill that has been officially released, which is a difficulty because you cannot comment. I would say that certainly in some regards what we have had to say has been taken on board and my opinion is that in most of those situations it was a necessity because there were real problems, huge problems.

But the idea of why we are getting an act, the intent or the results of the consultations that came back, the strengthening of the safeguards, the focus on the human rights et cetera, have not in our opinion had the effect that we would have hoped.

**CHAIR** - We have had a medical practitioner suggest that people should not have legal representation at the tribunal unless there was a particular reason they should, that it should not just be a broad thing that everyone has legal representation. The basis for that was that for the board to make a full assessment of the person's status they need to be able to speak up for themselves and a lawyer might think that if that person speaks up

they would actually dig their own grave, so to speak, and end up on an order or a continuing order or whatever. If a person is instructed by their lawyer not to speak they may not actually get the best outcome. Do you have a view on that?

**Ms WILLIAMS** - I have a very strong view.

**Mr HARDAKER** - I will make a comment then seeing that you have done most of the talking.

I am surprised at that comment because the way representation is provided in this State is quite different to how it is provided in other States. Up until 2002-03 there was no representation before the Mental Health Tribunal, even though the act said that everyone was entitled to representation before the tribunal, and that relates to the United Nations principles that refer to the fact that people with mental illness before hearings and reviews are entitled to that. Tasmania has that enshrined in legislation but there was no means by which that was provided, so it was a hollow right.

The Mental Health Advocate's position now occupied was funded in about 2000 or 2001 and when that position was first established, Debra Rigby, who had just been appointed as the president of the tribunal, then approached us to ask us would we now provide that representation because Legal Aid had said that they did not have the resources to do it and they could not do it so there was no way of it happening. Given the numbers of people that have hearings, the Mental Health Advocate's position would have done nothing else but represent people at hearings so we said, 'No, we won't but we will try to help find a solution to this'. Over the next couple of years we worked with the tribunal and Mental Health Services to try to get some funding for Legal Aid to take this on. We were unsuccessful with that and so what then resulted was a scheme that Valerie initiated where we are in partnership with the University of Tasmania Law School where we train students in a particularly non-adversarial model of representation and those law students act as volunteers and for the last five years have been providing that representation before the Mental Health Tribunal at hearings.

In the north and north-west of the State because there is no law school we recruit other people to do the work, interested community representatives from a range of fields, so that has been working very successfully now for the last five years. The representatives who are essentially lay advocates are appraised by the Mental Health Tribunal and so Debra primarily is our quality control officer and she reports on any hearings where she believes that the representatives have been out of line and have taken a more traditional adversarial approach to their representation and they are counselled very strongly as part of their training not to go down that road.

Part of our belief, too, was that by working with the law students, habits have not been formed at that stage and it gives them a very practical opportunity to learn about therapeutic jurisprudence and how you assist somebody to put forward their views in a Mental Health Tribunal hearing as much as possible with the person talking for themselves but, where the person is unable to do that, to put those views forward. Our representatives essentially meet with the person for one hour before the hearing; they talk to them about what message they want to get across to the tribunal and they also talk about who will do the talking. Then they attend the hearing together and provide that

representation. It really does work very effectively and it does not take that style of adversarial approach the clinician referred to.

**Mr MARTIN** - Do you think there is ever a situation likely to occur where in pursuing the desire of your client as an advocate you could actually be working against the best outcomes in terms of the medical wellbeing? Would that ever replace the rights of the person to dictate their own outcome even though it might not be the best medical outcome?

**Mr HARDAKER** - The message the representatives get very strongly as part of their training is that they are not the decision makers; the decision makers are the tribunal. The tribunal does this all day every day and has a lot of experience. They also know a lot more about the patients at the hearings than is included in the information the representative has. The representative's role is to help that person get their message across, whatever that message is. They are not to be judgmental about that particular message. If the person says, 'I don't have a mental illness, I shouldn't be here. I should get out', the representative helps them get that message across but it is the tribunal that will decide.

**Mr MARTIN** - It was put to us that if, in pursuing the outcome that your client wants, you determine that it is best served by them not speaking, that therefore limits the ability of the tribunal to make a decision.

**Ms WILLIAMS** - I think you are referring to Dr Schneider and what you are talking about are hearings before the Forensic Mental Health Tribunal. That is completely separate to everything that Ken has said, because we are talking about the Mental Health Tribunal. 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 people appearing before mental health tribunals can be locked up against their will for six months - in blocks of six months. Some are locked up for several blocks and we are talking about years.

With regard to treatment, we have the issue of bodily integrity. Again, somebody is going to come into your body and administer highly psychotropic drugs against your will. This is why you are entitled to independent review and legal representation. I want to make it very clear that if indeed what you are referring to is possibly Dr Scheinder's evidence. She is at the Wilfred Lopes forensic unit and what she is talking about is different - she has no experience with the Mental Health Tribunal as such because she is a forensic psychiatrist. It is a separate issue and, no matter what Dr Scheinder says, you can get lawyers out because these people are entitled to lawyers.

**Mr HARDAKER** - Our volunteers don't represent at the forensic tribunals.

**Ms WILLIAMS** - No, we don't do that. We only appear at the Mental Health Tribunal. It is a health setting before Debra Rigby and her other tribunal members. It is informal - our scheme is a therapeutic jurisprudential model, much like you would envisage with drug courts et cetera. It is the same model, with that health setting. Everybody is looking to get best outcomes but ultimately it is the tribunal that is the decision maker.

**Mr WILKINSON** - Isn't it the case that if the tribunal wished to hear from the individual they could do so?

**Ms WILLIAMS** - They do hear. We don't speak unless the person says, 'Can I speak?' Because it is informal and inquisitorial that is the skill of the tribunal.

**Mr WILKINSON** - That is what I am saying. Where the previous person said that the solicitor could speak and therefore somebody could stay mute beside them; that can happen.

**Mr HARDAKER** - Debra Rigby put in her annual report a couple of years ago that since the scheme commenced and the representatives have been provided, patients are much more forthcoming and confident in speaking up for themselves.

**Mr WILKINSON** - Sure. If a solicitor, for whatever reason, wants somebody to remain mute, is it up to the tribunal whether they wish to speak with that person?

**Ms WILLIAMS** - Absolutely. There are no rules of evidence.

**Mr WILKINSON** - That is right, so they are not gagged in any way.

**CHAIR** - Is there anything else you would like to add or any particular point you would like to make in closing?

**Ms WILLIAMS** - With the current situation politically and financially, the convention, the with the discussion around Tasmania's charter of rights and where that is going to sit, I think that it is a good time to be taking time and properly reviewing all the legislation which, because of the convention, we were legally required to do as of July when we ratified it. I think that the process we followed has been hurried and has not had the proper review that we would have expected, consultation-wise et cetera. We are going to end up with something that we are not in a position to implement anyhow. It is a good opportunity because we are not going to lose the work. The good work that we have done in the review is still going to be there. We are not going to trash it, but we could take the time to work on that and come out with something that is really good.

**Mr HARDAKER** - Commenting on the safeguards aspect, which has not had much attention, I think the systems oversight issue is a very important one. Particularly we should look at the public advocate-type role that exists in some of the other States where it has been effective at monitoring how well the system is working on an ongoing basis, rather than waiting for a review to happen every few years and then look at the problems that arise. It becomes a much more dynamic process. I think the issue around official visitors is also an important one.

**Mr DEAN** - I had marked to ask you questions on that but we are out of time.

**Mr HARDAKER** - We did mention in our submission the notion of looking more broadly than just mental health. Again, in other States there are often community visitor or official visitors programs around people with disabilities, particularly for people with profound or severe disabilities. We have many people living in residential services in our State who are unable to speak for themselves, some of whom have no-one in their lives other than the paid service providers. I am not saying those service people are not doing a fabulous job, but we know from experience that you also need people looking in from the outside to make sure things are working properly for people. We would like to see an official visitors or a community visitors program broadened to include those particularly vulnerable citizens. The last area we think is certainly very poorly funded is advocacy. We have one mental health advocate for the entire State.

**CHAIR** - None on the north-west coast.

**Ms WILLIAMS** - Nor in the north.

**Mr HARDAKER** - We have one advocate based in Hobart. That is all we have ever had. We had an independent report done in 1996, a Commonwealth-funded exercise, which said there needed to be at least one advocate in each region plus a fourth advocate to cover rural and remote areas. That was 12 years ago.

**CHAIR** - Mental health problems are increasing in our rural areas. Is the Government listening to this message that you are putting out?

**Ms WILLIAMS** - They are to the extent that they say, 'We agree with you but we do not have the money'. I have been doing this for 10 years now and I would really like some help. On that, the UK with the new Mental Health Act 2007 has brought in with that act that everybody on a mental health order actually has an independent mental health advocate. Again, that is identifying a trend in other jurisdictions, but Tasmania still has just one mental health advocate.

**CHAIR** - Thank you very much for your time and your submission.

**THE WITNESSES WITHDREW.**



**Ms MICHELLE SWALLOW**, MENTAL HEALTH COUNCIL OF TASMANIA, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

**CHAIR** - Thanks Michelle. I think you have met the other members of the committee.

**Ms SWALLOW** - Yes.

**CHAIR** - We have received your submission and read that. If there is anything at any time during the hearing here that you'd prefer to be said in camera, particularly if it relates to particular cases or anything like that, or whatever, just let the committee know and we can consider that.

**Ms SWALLOW** - Okay.

**CHAIR** - Otherwise, it will be public; it's being recorded and the media are here as well. It would be helpful if you would give an overview of your submission, particularly the main points you would like to raise and then we will have some questions for you.

**Ms SWALLOW** - The Mental Health Council of Tasmania, as you'd note in the submission, is the peak body representing the not-for-profit community mental health sector. We represent consumer organisations, family and carer organisations and service providers. We currently have 23 member organisations that we represent in the State and we really work with those organisations and with consumers and carers to provide a public voice.

One of the things that we said in the submission was that because of the time frame it was very difficult for us to consult with everybody during that very busy period to get lots and lots of input so some of it was verbal and some was written submissions.

Our submission was saying that we are aware that the current Mental Health Act is being reviewed and that the Government had undertaken to also have a look at the Alcohol and Drug Dependency Act with the reviews that are happening in the alcohol and drug sector. We noted with interest that you'd asked to have a bit of a look at what's happening and certainly probably the main points from the submission are that we think that all of the acts probably need to be reviewed. In the current political climate the human rights movement and possible acts happening would suggest that all acts that affect people's treatment under any sort of health regime would need to be considered in line with that - with legislative changes around that process.

We're pretty interested in our preparation about the UK models around capacity and we certainly know that others have talked about that as well. The Mental Health Council has not been entirely happy with the current process of drafting; it's taken a long time. Certainly, there isn't a draft bill that we've been able to look at and consult about before speaking with you today. We've been told in meetings we've had with the Health minister that in the current economic situation there's not likely to be any money to implement the act, if and when it's finally proclaimed. We're greatly concerned about that and the effect it might have on consumers of mental health services and their families.

**Mr WILKINSON** - Have you found that to be a problem in recent times; that people are feeling sympathetic towards your problem and yet they're saying they can't do anything because they haven't got any money?

**Ms SWALLOW** - Yes; across the board for many things. When something like a mental health act is being reviewed there's a lot of optimism in the community, certainly from our member organisations who represent consumers and carers. They are really hoping that people with mental illness will be able to have much more say in their treatment and really participate in that. The Department of Health and Human Services is considering a carer participation framework which is also being reviewed at the moment. It does not really line up with anything to do with the act, it is much more at an individual level. There is a whole suite of things that could and should be changed when the new act is proclaimed but I am not convinced by the processes of it. We have been involved, really getting to a point where it is looking at capacity to make decisions rather than you will need to have this done to you because your safety and that of the community is at risk.

**Mr DEAN** - Can I just ask one question on the fact that there will not be the money there to implement any new act? I asked the same question of a previous person: do you think that that position might impact on the way in which the review is undertaken and the way the new act or the new amendments might be written, to avoid the cost as much as possible rather than writing it in the best interests of the patients and the people that will be involved?

**Ms SWALLOW** - I don't believe so. I believe that the people who will be drafting the bill and the reference group who are reviewing it when it comes backwards and forwards would have the best interests of consumers and clients in mind rather than the cost implications. The process in that regard is sound, I believe, but obviously the concern is - and it happened last time - that an act goes through and it is there and the bill is accepted as an act and then it is not implemented. It has happened with the Child and Families Act as well. By the time it is actually implemented it is out of date.

**Mr WILKINSON** - Michelle, it is an interesting comment that you make, that mental illness is highly prevalent in Australia and that 45 per cent of Australians have experienced a mental illness at some stage in their life with 20 per cent having experienced it in the past 12 months.

**Ms SWALLOW** - Yes.

**Mr WILKINSON** - Where do those statistics come from? That is much higher than I thought it would be.

**Ms SWALLOW** - The Australian Institute of Health and Welfare have those statistics, as do other organisations such as SANE Australia and beyondblue, so it is common knowledge now that one in five of us at any given time has a diagnosable mental illness. The thing that is of concern in Tasmania is that only 35 per cent of people who have a diagnosed mental illness actually access public mental health services. The Commonwealth initiatives around accessing psychiatrists, psychologists and social workers through their Medicare rebate have gone some way to addressing that. But perhaps it's more the worried world than people who need to be accessing emergency treatment, and then

really focusing on the recovery, because you can recover from mental ill health. Many of us do but it takes a lot of support generally from community organisations.

**Mr WILKINSON** - Have you found that the actual definition of mental illness has become broader in recent times for these statistics to be available?

**Ms SWALLOW** - I think probably initiatives such as beyondblue and headspace, which we have in Launceston, have gone some way to addressing the stigma. There is still a long way to go before people can safely say they have a mental illness and access employment opportunities or education, for example. I think initiatives such as beyondblue have raised awareness that it is okay to say 'I have depression' or 'I am depressed and I need to access treatment for a period of time and then I can recover from that'.

**Mr MARTIN** - Would the things you have been talking about extend beyond the five major categories of mental illness?

**Ms SWALLOW** - Could you explain that a bit more, Terry?

**Mr MARTIN** - I was working with a case last week and, without going into too much detail, apparently the Department of Emergency Medicine will not accept anyone unless they have been diagnosed with one of the five major categories, which therefore means that a lot of people miss out on services.

**Ms SWALLOW** - Certainly I think when places, particularly in acute facilities, are limited or time is limited or beds are full, people who have things such as personality disorders, which may not be as readily acknowledged as a significant mental illness, may not be treated in quite the same way as someone who might have bipolar or schizophrenia or depression. So yes.

**Mr MARTIN** - We are not really dealing with that group of people at all, are we? The impacts on them and on the people around them can be just as great as -

**Ms SWALLOW** - If we have people who can advocate on their behalf and we have case coordination where people are involved both in prevention and early intervention as well as awareness-raising around health promotion I think we can and do treat and support people who have mental illnesses that do not necessarily fall into those five categories that you talk about.

**Mr MARTIN** - So the figures you were talking about related to the broader category?

**Ms SWALLOW** - Yes.

**CHAIR** - Coming back to the issue of costs, the discussion paper came out in August 2007, and in August 2007 the economic climate was considerably different to what we are facing now. The people driving the review will be focused on the best interests of the patient, outcomes and that sort of thing, so in light of the economic climate at the moment do you think that is even more prevalent? There was a suggestion that maybe we should just not worry too much about the bill that might or might not appear this sitting but really encourage that broader review. Do you think we should proceed?

**Ms SWALLOW** - It's a hard question because it's in the context that there are many pieces of legislation that need to be reviewed to look at people's rights and access to services that suit them at the time that they access them. The global financial crisis is affecting all of us. The new unemployment statistics are due out today and we really don't know the full effect yet of the economic crisis. Certainly people who may face tougher and tougher situations, particularly with things such as housing and homelessness, are a huge issue in terms of social inclusion for people with mental disorders. That can only get worse.

One of the things that the Mental Health Council has been doing with our interstate colleagues is an industry alliance called Community Mental Health Australia. I was just saying to Ivan that we've just been meeting in Canberra with officers from Prime Minister and Cabinet, FaHCSIA and the Department of Health and Aging saying that the stimulus package that is being discussed currently really needs to look at how you are going to support people who are homeless now or who might be at greater risk of homelessness, and certainly people with mental illness are the most at risk in that category. So, to have an act that really addresses the need for people to access emergency interventions when and if they need it means we cannot not continue with the act.

**CHAIR** - There is evidence from the Guardianship Board that that is a broader piece of legislation that enables potentially earlier intervention, whereas the Mental Health Act only relates to a very small percentage of people in our community. It's only the people that have severe mental illnesses that require significant treatment against their will - or where it's not their choice. Is focusing on such a narrow part of the population another reason to look at how we can perhaps broaden it out to be more inclusive of people, not that we're going to apply that Mental Health Act to the other people who have perhaps earlier symptoms or whatever. Is that the way we need to do it? The comment was also made that we don't have a cancer act, we don't have a Parkinson's act and we don't have an orthopaedic act; we have a Mental Health Act and no other area of health is particularly picked out. Do you want to comment on those sorts of issues?

**Ms SWALLOW** - Currently the act is looking at urgent circumstances and it's about safety for the community itself. It is very much focused on that and it looks as if the new act will similarly be focused on that. If one in five of us is acknowledged as having a mental illness at any time we may not need that urgent circumstance as part of the act. So the Mental Health Council is saying that if there is an act or a piece of legislation in place that says you can be treated against your will then that could be for any of us who might, at the early intervention stage, decide to admit ourselves for some intervention and support. 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.

**Mr WILKINSON** - And when should it happen, because some might say you're putting an ambulance at the bottom of the cliff rather than a fence at the top of the cliff?

**Ms SWALLOW** - Absolutely.

**Mr WILKINSON** - It's an interesting argument because, in relation to your cancer treatment, as you've just described, it's up to you whether you take it or not. It's a different thing to say, 'Look, if you take this you won't get cancer even though you might not have it now, but because your parents had it there's every likelihood that you might get cancer as well, therefore you've got to take this medicine.' Where do you cut in, in relation to this act? There is some argument to say you should cut in at the emergency stage because if you don't do that you are looking at a situation where it is preventive as opposed to a must take.

**Ms SWALLOW** - And like the Guardianship Board we would argue around capacity. What is the individual's capacity to make a decision about that at the point in time that they are being asked to have the treatment or take medication? That is a tricky one as well.

**Mr WILKINSON** - Where should it happen?

**Ms SWALLOW** - When people are in fact in-patients, not at an earlier point than that. I could give an example of a case where a gentleman was required, under Mental Health Services, to have daily injections of various treatments. He did not want to have those so he went AWOL. People knew where he lived so he did not go home, so he became homeless. Because he had gone AWOL he was unable then to be referred to a community sector organisation who might have been able to meet with him where he was at to ask, 'What is it that you want to do; what is happening and why don't you want to take it?'. It became punitive because then the police were involved to get this person - we have to treat them. That is really not a very good example of when the act is being used or when it is not used and what happens when somebody is in the community. He was okay enough to be in the community and the mental health team thought he was okay to be in the community. He was not actually an in-patient but they were able under the act to continue to treat him.

So there are some anomalies in the act which are spread a little bit at the moment and which I think need to be talked through. I am not a psychiatrist and I certainly do not profess to have the knowledge about when to make that decision.

**Mr WILKINSON** - Should it be left, then, in the hands of the Guardianship Board to make that decision with evidence put before them, and they make a decision on the best evidence?

**Ms SWALLOW** - Currently under the guardianship act one of the things that would be of concern, and I think we mentioned this in our report, is that there is not a point of review necessarily. I might be telling an untruth there; that may be to do with the Mental Health Tribunal. But for anybody, regardless of who makes the decision, there has to be a point in time where that decision is reviewed, because the very nature of mental illness is that it is episodic, unlike other health issues.

**Mr WILKINSON** - Is that the case now? They are reviewed?

**Ms SWALLOW** - Yes, they are.

**Mr DEAN** - But surely in all of this the professionals, the doctors, ought to be in the best position to determine whether or not a person should have treatment in their best interests. That is normally the process that they go through - their best interest to treat the condition that they have. Nobody is saying that at times they might not get it wrong because we all might get it wrong. So how do you remove that from those people and place it in the hands of some other body or authority?

**Ms SWALLOW** - I would argue that that does not happen. It is almost as Jim said; if you had cancer you can make the decision. Because it is a different sort of health issue I think the individual is best placed to decide on their treatment.

**Mr DEAN** - But even in the situation where there is real evidence that that person has self-harmed or threatened to harm others, would you still agree that that would be the position in that case as well?

**Ms SWALLOW** - Certainly in consultation with a psychiatrist but the individual would be involved in the decisions if they have the capacity to do that. That is the argument. It is about when they do. Are they making a decision based on being as well as they can be, with the capacity to understand what is happening for them and others?

**Mr DEAN** - That was raised with us previously this morning, how they should be tested for capacity to see whether they have the understanding. So you would subscribe to that?

**Ms SWALLOW** - Yes.

**Mr MARTIN** - Is the capacity test right at the moment?

**Ms SWALLOW** - I think that some individual practitioners certainly apply those principles but they also have to make decisions under the current legislation.

**CHAIR** - The comment was made that the Mental Health Act does not have a best interest component whereas the guardianship board does look after the best interest. The problem seems to be that there is a bit of subjectivity around all of this. Some people with a mental illness can be, a lot of them, very intelligent people, able to behave in a way that they know during assessment could create the impression that they are not suffering from mental illness or that they are well aware of the risks and benefits of the treatment or otherwise. The issue that has been discussed is that people without a mental illness can make a decision to refuse treatment and be respected, whereas those with a mental illness do not have the right under the Mental Health Act.

**Ms SWALLOW** - That's right. It is difficult to make a lot of comment until the new draft bill is out because we don't know if some of the issues that have been raised since that discussion paper was first written are going to be addressed in this new bill.

**CHAIR** - The Mental Health Act is one piece of legislation and is being reviewed. There have been suggestions that we should be looking at a more comprehensive review. Apparently the Yukon in Canada has removed their mental health act and replaced it with another piece of legislation. From your knowledge of working in the area, do you think there is another model we should look to for some guidance, particularly with the UN rights convention that we have signed off on?

**Ms SWALLOW** - The answer is yes but I wouldn't profess to know the model. I think there needs to be some research into other models across other jurisdictions and countries to look at what works most effectively for the people who are accessing interventions and the people who provide services for them.

**Mr DEAN** - From that point, have you looked at what is happening in the rest of the world?

**Ms SWALLOW** - No, we haven't. Because we are a peak body our role predominantly is about supporting our member organisations. I know you were talking with Advocacy Tasmania earlier and Val Williams has done some of that work, as has Narelle Butt at the Department of Health and Human Services. There has been work done, I believe, on looking at other models.

**CHAIR** - We heard from some people that Tasmania isn't that bad, that we are a lot better than other jurisdictions in the country. Have you had any experience with other jurisdictions at all?

**Ms SWALLOW** - Yes, I have. When you say 'not bad', in relation to what?

**CHAIR** - In the process of review, when an order is made there has to be a review process.

**Ms SWALLOW** - I had experience in New South Wales many years ago. Their act has changed since then so I can't really comment on it now. Colleagues interstate have said that 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.

**Mr WILKINSON** - There is one area in your report, Michelle, which I think is important. You say that 'a person who has received treatment involuntarily will have their case reviewed by the Mental Health Tribunal but there is currently no requirement to provide the tribunal with the reasons for the involuntary treatment'.

**Ms SWALLOW** - Yes, which makes it very hard for them 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.

**Mr WILKINSON** - That's crazy, isn't it, because, as you say, you can't review it unless you know the reasons for that person being placed on the medication or treatment in the first place.

**Ms SWALLOW** - That's right. It is about accountability. If you are doing something in someone's best interest, in your opinion - and at the moment under the act you have not

had any requirement to even discuss that with the person you are treating - you can do whatever you want. That absolutely has to change because every human being has the right to have a say and have intervention in their treatment.

**Mr WILKINSON** - But surely, if it came before the tribunal, the tribunal would ask, 'Why did you treat this person?' You are saying that the doctor can say, 'I cannot tell you'?

**Ms SWALLOW** - I am not saying that so much as it is not a requirement for them to provide the information under the current legislation.

**CHAIR** - We would probably need to ask the Mental Health Tribunal how they handle that situation.

**Ms SWALLOW** - Yes. I do not know how they do. I was just aware of it when we were looking through the different processes.

**Mr DEAN** - Going back to the negative stereotyping that occurs in relation to mental illness, how do we address that and do we remove from the act all of the references to punitive measures and control? Also, if we renamed it it would not be long before it might be given a negative connotation as well. What is your view there?

**Ms SWALLOW** - The Mental Health Council is a fairly new organisation. I think we have been around for about four years and came about through some different sorts of arrangements. We are about to have our first policy forum. We are going to be looking at de-stigmatisation across the board. There is no point in looking at a recovery model if there is still a lot of stigma, I would agree. It is about having inclusive language but it is also about addressing existing stigma with professionals who provide treatment and interventions.

There have been a lot of changes in the mental health sector over the last 25 years, and de-institutionalisation has meant that some of the staff previously employed in institutions are now employed in acute facilities. There has never been any work done in changing attitude, changing the way we use language, being more inclusive, really addressing the stigma of words. There are certain movements, particularly in New Zealand, where a lot of consumer-led organisations talk about 'mad pride' and really changing the way we think about mental illness. That needs to happen alongside any act that affects providing treatment to people when it is required.

**Mr DEAN** - I am of the view that if we could get rid of stigma that would be helpful. I think at least one in five with depression et cetera will not come out in the open because of the stigma; they would be labelled silly, crazy or whatever.

**CHAIR** - That is regardless of the legislation.

**Ms SWALLOW** - That is right.

**Mr DEAN** - Yes.



**Mr MARTIN** - Following on from that, a number of witnesses have talked about resources in improving the legislation. At the end of the day, do we have anywhere near enough resources going into mental health at the moment?

**Ms SWALLOW** - No, absolutely not.

**Mr MARTIN** - How deficient do you think we are at this stage?

**Ms SWALLOW** - As I said, I represent the community sector. In this State, the Government will say, 'We put 17 per cent of our total mental health budget in the community sector'. But 17 per cent of not very much is still not very much. Mental health is often funded in a way that is almost the poor cousin of other health issues. I do not envy any bureaucrat or minister who has to make decisions about that because the acute end is often the one that requires more resources. I think it takes a very brave government to make a decision about investing in primary health and prevention, promotion and early intervention. If we can, particularly through our education systems for young people, encourage help-seeking behaviour and de-stigmatisation around mental health then we are really going some way to addressing the need to use those acute services further down the track. If any money is ever available for more of the prevention and primary intervention end of mental health then that is a good thing. The Commonwealth initiatives around the Personal Helpers And Mentors Program and Day to Day Living and the money that has come into this State have greatly enhanced the capacity of communities to support people to stay in the community and to be as well as they can.

**Mr MARTIN** - Do you make a budget submission to State Government?

**Ms SWALLOW** - Yes, we do.

**Mr MARTIN** - What are the directives you are asking for?

**Ms SWALLOW** - This was the first time we had done a budget priority statement and it was very conservative. It was really asking for some money to be put into allowing the community sector to do some health promotion work around raising awareness of stigmatisation and destigmatisation and help-seeking behaviours. So yes, and there are a number of other areas which I cannot remember off the top of my head.

**CHAIR** - I know that you are basically representing the consumers more than the medical profession. In our term of reference (2) we are asking about whether we think Tasmanian legislation meets world's best practice in terms of providing clarity and certainty for medical practitioners and support workers, which you are involved with. There has been comment made that the medical profession are often confused about which act they should be looking at because the Mental Health Act only provides for a specific and fairly narrow range. Potentially patients can fall between these gaps. How do you see that could be addressed and do you think we need to move to address that?

**Ms SWALLOW** - Certainly it is a large issue around dual diagnosis to do with co-morbidity - mental health and alcohol or other drug issues. Rather than at the legislation end it is more about the accident and emergency or crisis end, so when someone presents it is much better in the last five years in accident and emergency in all of the hospitals.

**Mr MARTIN** - It is better in the last five years?

**Ms SWALLOW** - Yes, it is, in that they have people that are more accessible, so psychiatrists or registrars will be on call and will be able to go and say to someone that this is a drug-induced psychosis. But the decision about where that person then goes for treatment is not always an easy one. That happens in the community sector as well. If I present at a service and there is an assessment done and somebody says you have a mental illness but now you need to go over here and be assessed for your alcohol and other drugs, then I am probably not going to turn because I have already done it once. So some of the work that is happening through both ourselves and the Alcohol, Tobacco and Other Drugs Council, the peak body for the alcohol and drug sector, is how we address that. We are members so it does not matter where you enter a system; you are going to be provided with support.

In terms of the legislation and how that helps professionals to make decisions they really do need some capacity to make a decision about which act I am going to treat this person under. In the future they need to have something that really again is about the individual's capacity to make a decision for themselves and then the medical or treating person's, the support person's, decision about whether I have to do this under this act for the best interest of the person. It does not really matter what act it is; it is about the person getting the treatment that they require.

**CHAIR** - Do you think if there was an act that was inclusive of the roles and functions of the Guardianship and Administration Board and the need for detention and treatment people, but it was not called the Mental Health Act because that can have its own stigma, that that would be an appropriate way forward, one that encompassed all those roles and functions?

**Ms SWALLOW** - Possibly, and I would be to see it in a draft form to make that comment. I know that in the UK, under their capacity act, it is very much one piece of legislation that is saying let's take into account all of these things that will really be in the best interests of this person, particularly focused on the episodic nature of mental illness and that people can recover.

**CHAIR** - So under that act, the mental wellness of a person is also considered along with their capacity to make decisions for whatever reason and their physical health and the limitations that may be to do with that?

**Ms SWALLOW** - Yes, and access to services is a part of it as well, I believe.

**CHAIR** - Legislated access to service?

**Ms SWALLOW** - Apparently. It is not just the capacity of a person making a decision; it is a capacity for them to access a service when they need it.

Thank you for looking at this. I think it is a strange time to do it given that the draft bill is not extant. Anyway, 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 a community rights point of view and I think that is really important.

**Mr MARTIN** - Do you believe the new legislation should be implemented on the basis of this mental health review rather than wait for the review of the three acts? Would it better to review the three acts first?

**Ms SWALLOW** - I think there are probably arguments for both. I think the risk of waiting for the three acts to be reviewed is that the current Mental Health Act desperately needs to be changed, but because I have not seen a draft bill I do not know whether it is worth waiting or not. I sort of agree that it is worth waiting from a principle point of view but I am concerned that that is going to take longer and that people are still going to be treated in a way that is not inclusive or acknowledges that people have a right to make decisions about their treatment.

**Mr WILKINSON** - So even though the whole house needs to be renovated, if that cannot occur doing a couple of rooms is better than nothing at all?

**Ms SWALLOW** - Yes, maybe, if I could see what the room is going to look like.

*Laughter.*

**CHAIR** - As an explanation, when I proposed this committee I was very well aware of the work that had been done in the Mental Health Act review and it has been going on for some time. I was assured by the minister that we would have a piece of legislation this sitting but that remains to be seen of course. If a draft bill has not been out to the key bodies at this stage then I doubt that is likely to occur, but time will tell. The point of it is that there are other acts that need review, we have been told, and this is not necessarily about stopping or impeding a process; it is about looking at what is best for the future.

**Ms SWALLOW** - Yes, and how it can all dovetail together.

**CHAIR** - Yes. Thank you for your time.

**THE WITNESS WITHDREW.**

**Mr ANTHONY ROBERT GORDON ABEL WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.**

**Mr ABEL** - As pretty much indicated in my submission, my concern with respect to the inquiry was limited in certain respects to the issues of overlooking the review, though I have opinions and some background with respect to a number of other matters. I have spent two-and-a-half years writing a thesis about an international review mechanism with respect to mental health services. It is a quite detailed comparative review.

**CHAIR** - Have you completed that?

**Mr ABEL** - I have indeed and if the committee wishes I am more than happy to make it available to them. I have tried to narrow my focus that far simply because I do have quite a lot of knowledge in that particular respect.

The reason for my undertaking that thesis in the first place was that from 2002 to mid-2006 I ran the official visitors. I was coordinator of the official visitors under the Mental Health Act in Tasmania and so got to experience that process in its entirety, as it were, and also to look at what was done elsewhere in Australia. I then had the opportunity to study through the University of Northumbria in the UK, which took me in particular to looking at the British legislation and the impacts of the European Convention on Human Rights on law as it applies across the British Isles and all members of the European Union and other European nations which have become signatory to the convention.

My thesis looked at all Australian, New Zealand, Canadian and British jurisdictions. I guess I was trying to come up with an idea of what amongst this plethora of methods of oversight would be best applicable to Tasmania, or Australia generally. There really is quite a wide variation in the way these things are approached. It suggests that there are no one-size-fits-all kinds of approach but that there are a number of different approaches which could usefully be considered in this respect.

The reason I think it is important is that this study took me back to the history of these types of mechanisms and to the origins of mental health systems as we currently know them, which effectively can be seen as commencing in about the late eighteenth century in the UK. There has been a process of moving from poorhouses, workhouses, through an asylum system to de-institutionalisation that we are experiencing now. The parallel to those processes has been the system of oversight, which has varied in different places. There has been a system of oversight, recognising the vulnerability of people who are subject to such compulsory systems - or not just compulsory systems, but also systems where people might find themselves deprived of fundamental rights and perhaps ill-treated not necessarily compulsorily by a State but at the behest of well-meaning relatives or not-so-well-meaning relatives. There has been a parallel growth in variation of the systemic approach to mental health but also a recognition throughout this time that there needs to be oversight and review applied to this system.

The Official Visitors under the Mental Health Act, which I was then running, was our Tasmanian adaptation of the British models which have evolved literally since the first commissioners were appointed in 1774, so there is quite a history to these things. I have a number of opinions as to why those mechanisms are as relevant and essential today, in my opinion, as they have ever been.

**Mr WILKINSON** - The Bamford report you quoted, is that the latest report in relation to matters such as the ones we are looking at now?

**Mr ABEL** - Yes, it is. It is the latest British one. The Bamford report is an astonishing body of work.

**Mr WILKINSON** - Is it a good report for us to take heed of?

**Mr ABEL** - Yes, it is excellent, but it is only one of a number of reports. Looking at the British system through the light of the European Conventions was an absolute eye-opener for an Australian because we just don't think that way; we don't have those types of mechanisms. British systems have been under constant scrutiny since about the late 1990s. The first big report was by Genevra Richardson, the Report of the Expert Committee in about 2000. Professor Richardson is hugely respected authority. She had an expert committee and they looked at the UK system. UK, in jurisdictional terms, is England and Wales, with Scotland, Northern Ireland and the Republic of Ireland as separate jurisdictions.

At the same time there was an even more impressive report in my opinion, as good as Bamford's if not better, by a bloke named Millan in Scotland. Similarly, it entailed about three years' work with a cast of thousands, very expert and it is about 600 pages long. It is wonderful to see that much thought being applied to these questions. Bamford started running in about 2002 and finished in 2006-07. At the same time, there was a similarly important report, again hugely extensive, by the Senate in Canada, the Kirby report called 'Out of the Shadows'. It is also an enormous document which took about three years to write. It led to the establishment of the Mental Health Commission in Canada. Kirby reported in late 2006 and the Canadian Mental Health Commission was set up in early 2007. There was a similar report in New Zealand by a chap named Mason in the mid-1990s which led to the establishment of the Mental Health Commission in New Zealand.

Australia has its visitor programs, such as the Official Visitor program here, in each State and Territory except South Australia. In some respects our visitor systems reflect very strongly the British models but they lack the sort of intellectual rigour and resourcing that the British models have had traditionally for 200 years. There is a trend that is occurring, and I know that it has been referred to in other submissions which I have read. 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.

What is occurring, and one of the things that I think is possibly important for this committee to be having a view to, is that rather than simply having these commission oversight bodies that look at mental health as a separate thing 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.

**CHAIR** - So are you suggesting then that the proposed review by Anita and Debra is looking at a piece of legislation that encompasses the Guardianship and Administration Board role as well as the requirements under the Mental Health Act to treat? Are they saying that should all be under the one piece of legislation?

**Mr ABEL** - Indeed. That is why I think I indicated in my submission that that broad thrust of Debra's and Anita's paper is one that I would support, certainly from having seen what has been happening overseas. I am not quite sure about the way in which they would operationalise that. In other words, I think the principles are maybe a little bit off the mark but the general idea of bringing together the question of services for people with a disability is consonant with what is happening overseas and it is also consonant with the requirements which we have just ratified as a nation under the 2006 convention which does not distinguish between people with mental health issues and other disabilities, it simply applies to people with disabilities. There is no longer this artificial distinction of people with something that can be categorised as a mental illness and some other disability like an acquired brain injury or an intellectual disability that might have very similar impacts. The articulation around this idea of incapacity is that for each of these conditions you have people who are suffering a lack of capacity, thus they need to be thought of and maybe dealt with in a very similar sort of fashion. You can have a body of the legislation that picks up the condition of incapacity and says this is how we deal with people who are incapable; it does not matter what is causing the incapacity.

**CHAIR** - Can that still work in a crisis situation? You might have someone who lacks capacity because of a permanent brain injury, and they would have a guardian or someone who is going to make their decisions for them in regard to their medical treatment but also their finances and where they live and all those sorts of things. Apart for the original injury, those people are not likely to present in an emergency situation but someone with a drug-induced psychosis can present in an emergency situation where they lack capacity at that particular time because of the impact of the drugs. Is there a system that would meet both those needs? This is where it seems to be the thin edge of the wedge in the A&E when you have someone with a severe psychotic episode who at that particular time probably does not have capacity. But that is not for me to decide, it is for someone else.

**Mr ABEL** - I guess it raises a lot of issues. I have been concerned for a number of years that sometimes the question of capacity does not get looked at very well. This is an issue with respect to the 2007 convention, that people who retain capacity are treated against their will, which is now basically unlawful internationally. Our laws do not work with that too well.

I think the easiest answer to your question is that people coming into A&E or in other circumstances - for example, a road accident - who need urgent treatment by virtue of their condition may be treated under common law on the basis of that urgency. The question, looking at it as somebody who had responsibility for an oversight system, is whether or not our services from time to time actually are sufficiently scrupulous in how they regard a particular set of circumstances, and is the situation indeed urgent? Is it in fact a danger and so forth and so on. So at one end of the spectrum, yes, it is easy. So

when it is clear that the situation requires urgent measures the common law has dealt with that well for centuries and continues to do so. Where it becomes more difficult though is where there is some doubt as to whether or not that person actually retains capacity. If they retain capacity one of the things that the 2006 convention is saying is that you need some basis other than the fact that the person has some form of disability to actually perform any act on them because, if you retain capacity, you have - in the words of one Canadian judge, a person who has capacity has the right to make any decision that any reasonable person would consider foolish and unwise because they have capacity.

**CHAIR** - People do that all the time, don't they?

**Mr ABEL** - Exactly.

**CHAIR** - I have capacity and I can make decisions that are foolish or unwise in the minds of some.

**Mr ABEL** - Precisely. One looks at the exercise of the Mental Health Act from time to time and thinks 'there but for the grace of God go I on a 72-hour order'.

**CHAIR** - So are you suggesting then that common law could actually apply to people in that acutely psychotic condition, as it does with someone who is potentially bleeding to death and is a Jehovah's Witness whose particular view on blood transfusion can be overridden, particularly if it is a child?

**Mr ABEL** - Certainly with a child. But there are some very interesting cases in the UK where the rights of people to refuse life-preserving treatment have been upheld. Without question the person is capable, and they have the right to make that decision, however unwise.

**CHAIR** - The question has been raised with someone earlier about the issue of capacity with the mentally ill, that their capacity is based on delusional thoughts and a delusional view of their world and their health. The main delusion is that they do not have an illness at all. Where does the capacity argument come in that? This is one of the really tricky areas.

**Mr ABEL** - It certainly is. I am afraid I do not have a magic wand for that one either. I guess the kind of things that you have to separate out in that case then are whether the effects of the delusion are such that they are influencing their behaviours in a way that requires some kind of taking away of their individual autonomy, of their right to make even however-unwise decisions. I guess I am arguing here the international human rights sorts of arguments which, as I say, are an eye-opener to anybody from an Australian jurisdiction because we really do not have regard to these questions in the way that they are now being addressed internationally.

Michelle was asked a question earlier about the process that is being undergone with respect to a review of legislation at this point, and whether or not one goes ahead with the current review of the Mental Health Act or whether one steps back a little bit, like Anita and Debra are suggesting, and thinks, as the Europeans have now done and the British, we need to actually treat this type of legislation as a suite. The reason they are doing so in Europe and Britain is the impact of the European Convention on Human

Rights. The way that works is that all legislation in countries which are signatory have to conform to the principles of the convention. If not, it can be taken to the European Court of Human Rights and the legislation concerned can be deemed non-compliant. Depending on the way in which countries have chosen to be part of that convention, that will be dealt with by different governments in different ways. But what happens, for example, with the British jurisdictions is that a decision that a law - some particular treatment or provision - is not compliant with the convention is referred back to the parliament or to the government of that country. It will then be taken back through parliament and that's the proposal that was largely being put forward by the Law Reform Commission here, in terms of their paper last year with respect to a charter.

**CHAIR** - So it is really a requirement for all these acts that we refer to, to be reviewed anyway?

**Mr ABEL** - That's precisely what I'm saying, effectively. Really, we should be taking a step back, particularly given that we have now ratified the 2006 convention. I've been giving what I say here today a great deal of thought, but it strikes me that the effect of the 2006 convention is, in fact, to virtually impose on us, by our own voluntary acceptance of an international standard, a human rights framework which we haven't had before. It really is a profound human rights framework.

**Mr MARTIN** - Just to clarify, are you saying we should hold off on any changes to the Mental Health Act and wait to do a review of the suite of them or -

**Mr ABEL** - How do I answer that? I wrote a couple of papers for Advocacy a couple of years ago at the start of the submission phase for the mental health review and Advocacy then suggested that, yes, this process should be slowed down because what is now occurring was going to occur; that this convergence around the human rights principles was coming down the track to us. You can see it happening internationally so widely that I'm afraid I don't think Australia's going to escape it for very much longer. Two Australian jurisdictions have already picked it up - the ACT and Victoria have now human rights charters or frameworks, anyway. Both of them report that they're working pretty well; that there's no drama; nothing's revolutionary; there's incremental change occurring, which seems positive. That's certainly the British experience too. When they ratified the European convention back in 1998 - it came into effect in 2002 - everybody was going shock, horror; this is going to do terrible things to our law and our sense of integrity as a nation state. It hasn't happened. Those principles are now overarching all the British jurisdictions and most of Europe. Countries are not having trouble complying with them. It's not radical; there's nothing outrageous about it.

As a matter of principle, I think, it would be very sensible for us to be sitting back looking at the three bodies of legislation - that is the Mental Health Act, the Alcohol and Drugs Act and the Guardianship Act, conjointly, much in the way that Anita and Deborah are proposing, for example, but certainly as has occurred in Scotland, in the Republic of Ireland and in Northern Ireland. In the UK, England and Wales haven't gone quite that far, though they have put in place the 2005 Mental Capacity Act. So, they are running a mental health act alongside which permits involuntary treatment et cetera, but at the same time they've put in place the 2005 Mental Capacity Act, which protects all of those other people who have a disability and who lack capacity. So, they've bitten half the bullet, for want of a better way of putting it.



**CHAIR** - It's interesting. I was interested in how they kept their mental health act as well rather than trying to combine the two. It seems to be an interesting approach.

**Mr ABEL** - Well, that's right, and it was certainly a huge debate; the process of reforming the UK 2007 act was passed after the best part of 10 years of acrimonious and very fierce debate. It started back with Genevra Richardson's report, which commenced I think in late 1998 or early 1999. The two draft bills put into the British Parliament around the Mental Health Act were rejected and sent back. In the end, the third came forward not as a new act, which was the Government's preference, but as an amending act with respect to the existing 1983 act. It is seen as a compromise, as having bitten half the bullet. Scotland and the Republic of Ireland have gone much further. Northern Ireland, under the Bamford Report, I don't know where that is at just at the moment but it is clear that their intentions are that things go further yet.

**CHAIR** - Is this articulated in your thesis?

**Mr ABEL** - Yes, indeed - at considerable length!

**CHAIR** - In your submission you talk about the mental health and mental welfare commissions and you say that the British jurisdictions have all enacted independent commissioners charged with inspection, review, oversight and reporting on the care and treatment of those with mental illness and disorders. You note that Australia has official or community visitors and in which jurisdictions. You comment then goes on to say:

'None of the Australian bodies operate with the technical depth or expertise of their British counterparts, although the legislative powers, duties and responsibilities are very similar and draw from British models.'

Can you explain how the technical depth and expertise varies and why we don't operate at that level in Australia? Is it due to lack of resources? What is the challenge here?

**Mr ABEL** - I will just take one step back, if I may. Each of the reviews that I have talked about, and the UK reviews in particular, have recommended the strengthening and the widening of scope of these commissions. These commissions, like the visitor programs in Australia, rely on visiting and inspection. They are absolutely adamant that their great value derives from the fact that they have people who are generally representatives of the broader community rather than experts going into facilities, meeting with people, talking to them about their experiences, requiring records - because there are powers to require records and answers - and then reporting back into their organisation, to the commission. They are saying it is very important that we get the qualitative information from these visits which we can't get any other way. The system is not going to tell us about it itself, it has a vested interest and/or a cultural blindness to doing so. Getting people into these facilities, talking to people, looking at what is going on, famously it was put as 'sharp eyes, keen ears' - listening, looking and reporting back - is integral to those programs.

All the Australian visitor programs have those capacities and powers. What none of us have, perhaps with the exception of the Western Australians, is the power to take that information back, collate it, analyse it and report it in the public interest. In most cases the visitor programs in Australia don't report to parliament. I think Western Australia is

the sole exception. In some cases their reports are part of wider reports of an agency - Justice or perhaps Health - but that is always the case. By contrast, the British Mental Health Act Commission provides some of the most authoritative legal and analytical advice that is available anywhere in the world about mental health systems. The work is scholarly; it has my admiration, as does the Scottish Commission. It certainly looks like the one newly established in the Republic of Ireland, which is based on the very stringent sort of collection of data, analysis of that data and reporting in the public interests. The Government might not like its critical friend but that's what we are appointed to do and that's what we are going to do.

**CHAIR** - Do you think that's what needs to happen in Tasmania and possibly the rest of Australia?

**Mr ABEL** - Yes. If I was highlighting what's important to me about being here today, I would say that we do need that kind of approach. We need to be very serious about how we review these systems, not only with respect to mental health. Having spent the last year working as a disability advocate which was outside my previous experience, I am aware that under the Mental Health Act you have visitors who visit monthly and can enter a facility at any time of day or night and demand to see records and demand answers. With disability services there is no such provision and a lot of disability services are provided behind locked doors or hidden away in the community. As a disability advocate, I spend a lot of time working with those people, but I recognise that I'm only working with the people who, in some way, have found out that there's an advocacy service that they can use if they have issues. Many people with profound disabilities don't have the capacity to fend for themselves. They may not have somebody who has their interests sufficiently at heart to do so on their behalf. Those people are going to be overlooked.

I am saying it's very important to have such a system with respect to the mental health system and I believe that needs to be extended to the disability system. I know Paul Mason would say it also needs to happen with respect to children.

**CHAIR** - Can an encompassing piece of legislation achieve that?

**Mr ABEL** - I believe it could, yes. I think there are economies of scale which are achievable in those terms.

**CHAIR** - Do you think the lack of funding is a potential reason why we don't have that level of scrutiny now?

**Mr ABEL** - Yes, clearly there are resource implications and, as I said, Australia, as a nation, is not a very rights conscious. In fact, we've grown up in a conservative, common law tradition of saying that we don't really need words telling us what to do because the Commonwealth's always done it really well and we can derive all our rights out of the common law.

**Mr WILKINSON** - And it's always spoken about; the reasonable man test, hasn't it?

**Mr MARTIN** - That hasn't worked too well in the last decade.

**CHAIR** - Not many reasonable men about these days; that could be the problem.

**Mr ABEL** - I guess there's a third dimension to that. Apart from the vulnerability of the people we are dealing with - and that is the reason for these commissions in the UK over the past 200-odd years - it has always been recognised that there are people who are not going to be capable of looking after themselves and therefore might be being mistreated, or they might have been put away in a private asylum, which existed in the UK until the 1890s, because they were a bit embarrassing to the family or a little eccentric. You need somebody to be looking over the shoulders of the system checking whether the right thing is happening. I am not suggesting for a moment that this is commonplace or that it's happened in Tasmania on a daily basis because I would say it's not, but it's possible. With respect to people who are profoundly disabled and have no capacity to look after themselves, I think we have an obligation to make sure that the right things are happening in those services.

One step further increasingly we are moving away from government provision of services so we are devolving services away, as has been done in the rest of the world. We are contracting them out. By contracting them out we have organisations lining up to win those contracts for the right reasons. They are not-for-profit organisations but there is almost an element of organisational self-interest which gets built into that because they want specific contracts. It is widely recognised internationally that there is a certain level of a disincentive to be sharing information about what you are doing, how you are doing it, particularly perhaps if you are not doing it well because that might not go down too well with the people who are going to be paying for the next contract. There are certain commercial, organisational and also political disincentives because the minister does not need a very large report showing what has not worked, despite costing a lot of money.

**CHAIR** - One more reason to have it.

**Mr ABEL** - Exactly, which is why you have these independent bodies sitting above that kind of arena.

**Mr DEAN** - In relation to the rights and capacity of people to make their own decisions, it has been suggested to us that there are some psychiatrists who are saying that protection of the rights of people is so damned hard that they do not want to go down that track and therefore they are not providing the treatment that should be provided. They are taking that way out. It has been suggested to us in documentation that that is happening. Do you want to comment in relation to that? Also if we make it harder it might compound that problem.

**Mr ABEL** - As I say, I do not think there is an easy answer. One of the central tensions is between the right of a person to make their own decision and the right of somebody else to say, 'You are not making a wise decision or a reasonable decision as the Guardianship and Administration Act permits, therefore we are going to make it for you'. Again this is a widespread international tension, the tension between clinical perspectives and legal perspectives. Doctors want to make patients well, and they tend to do whatever is necessary to make them well. The legal perspective looks at the individual's right to determine how far they want the doctor to go to make them well, whether they want to be well, whether it is a delusion, for example, that they are quite happy to live with. I am

dealing with somebody at the moment who is delusional as blazes, but does not quite fit the Mental Health Act. Put in front of the Guardianship and Administration Board, I think the board would certainly recognise that often this person's actions were very unreasonable, but would also recognise that he is really pretty capable and therefore the board would ask whether it had the right to interpose itself between him and his unreasonableness.

**CHAIR** - Do you see his unreasonableness impacting adversely on others around him?

**Mr ABEL** - Not particularly, only in very minimal ways. If I had to answer in black and white I would say no, because it is annoying for some people but it is no more than that.

**CHAIR** - Anybody with capacity can be annoying.

**Mr ABEL** - As I am saying, this bloke is absolutely as delusional as heck in certain respects, but I would say he has capacity in most significant respects.

**CHAIR** - If somebody thought he was posing a threat to them in some way and there was a risk of dangerousness, potentially could he fall foul of the Mental Health Act and end up being treated against his will?

**Mr ABEL** - It would have to be a significant level of risk to himself or to others.

**CHAIR** - And he does not pose that?

**Mr ABEL** - He is certainly not presenting that in any respect at this point.

**CHAIR** - What if he were to be subjected to a capacity test? Would he pass it?

**Mr ABEL** - My gut feeling would be that yes he would, even though if you were to ask him questions in certain areas then no he would not. In general, in terms of his ability to look after himself, live in the community, to be tidy, well fed, and look after his house, yes he does that but he is certainly pursued by demons which in my opinion he can live without. That is only my opinion.

**CHAIR** - Allegedly at a pinch there could be treatment for him out there that might remove those demons, so to speak?

**Mr ABEL** - It is a very difficult case and everybody is struggling with what that treatment might be in this case, even though it is well recognised that there is certainly a lot of stuff which would light up in the Mental Health Act or in the DSM.

**CHAIR** - An individualised approach is really important, then. That is what I am getting from what you are saying, that you cannot put everyone into one box. Your framework must be broad enough to encompass people but not impinge on their rights where there is no need to do so.

**Mr ABEL** - Another element of my thing about the need for review mechanisms is the community treatment order stuff. The present systems in most part of the world are set up only to look at people who are involuntarily detained or are in institutions of some

kind of another. Increasingly care and treatment is happening out in the community. Our review systems at present do not extend into the community. They stop at the hospital door, yet 90 per cent of care is happening outside the hospitals. So something I would argue for very strongly is that these review systems, as now is the case in Scotland and Ireland, extend to everything that looks like a service being provided by one of these contracted service providers. The central reason for that is that it is happening there and it is out of sight if you do not have a mandate to look at it. What is happening there, outside in the community, or not happening there influences whether or not you are likely to come back into the institution. It is arguable that the notorious revolving door of cyclical mental health admissions is itself driven by the lack of services or by inappropriate services out in the community.

If review bodies, these independent bodies that I am arguing for, do not have the capacity to look at those services then you cannot examine the linkage between that need to use compulsory powers and what is being provided or not being provided out in the community. I would say that that link is actually extremely important and somebody needs to have an oversight of that. You simply cannot rely on a bureaucratic system which is responsible to political masters who have their own careers to look after to be necessarily highly accurate about what is happening there. People have good will and many people will do their job to the best of their ability but we do need to be aware that there are capacities or opportunities for people not to do or say as much perhaps as they could politically to not want to see that bad outcome. Hence these things get hidden under the table. That is not in anybody's interest, in my opinion. It is certainly not in the interests of people who are receiving services.

**CHAIR** - We will be asking more and more on community treatment orders. I have a view that we should be treating as many people as we can in the community because they need to live there; they should be part of our community where they can. I see your point that there are no checks and balances really in that area now.

**Mr ABEL** - There is a lot of very good literature about this but it is a huge international debate. It is really firing. Professor John Dawson from the University of Otago wrote a very good international study on this two years ago.

Two things about community treatment. One, community treatment generally means medication. The medications, particularly if you are schizophrenic, are pretty perturbing things and they can have pretty profound side effects. You have to be sure if you are going to treat somebody compulsorily with this stuff that you are only doing it when you have to do it because for some people it will ruin their lives. They will tell you that it ruins their lives. There is a famous case in Canada, *Starson v. Swayze*, where an internationally recognised astrophysicist who is a schizophrenic won a decision in the Supreme Court of Canada by saying, 'I understand what I am like when I am not medicated and I prefer to be not medicated'. The Supreme Court of Canada accepted that he had the capacity to make that decision. He fully understood what it was, and he said, 'The reason I choose not to be medicated, even though I have to be locked up because I can't be unmedicated, is that I cannot live with myself when I am medicated. My mind stops working'. This guy is recognised as having a brain light years ahead of his compatriots. He is hugely well recognised. His decision was respected by the Supreme Court to say, 'Right, that is your choice; you are capable and you are entitled to that choice'.

**CHAIR** - The medical practitioners struggle with that.

**Mr ABEL** - I know. I have spent a lot of time over the last few years having those arguments. Treatment is by and large meaning medication, and other people would say, 'What about the talking therapies? We don't have enough of them, which is why we resort to medication.'

The second set of concerns are that community treatment orders also go with conditions. There might be conditions about where you live, who you live with, who you talk to, who you do not talk to. Many people will again say that is really a very profound restriction of my right to freedom of association, of my right to determine where I live. If we are going to use those mechanisms then we need, I think, to have a very good set of eyes and keen ears to be getting out there and talking to those people and saying, 'How is this affecting you?' and bringing that qualitative data back. In European and British jurisdictions that is exactly what these commissions are now doing, and I really think we need to consider that.

**CHAIR** - Thank you for that.

**THE WITNESS WITHDREW.**

**Ms DANNII LANE**, INDEPENDENT MENTAL HEALTH CONSUMER ADVOCATE,  
WAS CALLED.

**CHAIR** (Ms Forrest) - I will ask you to read the statutory declaration before we start, if you would not mind.

**Ms LANE** - For medical reasons I am unable to comply specifically as it is written out. I can say that I, Dannii Lane, do solemnly and sincerely declare that the evidence I am about to give the committee is the truth as I understand it to be. Is that acceptable?

**CHAIR** - Yes. I have noticed that you have been here for some of the previous witnesses so you have heard the usual introduction.

**Ms LANE** - Actually no, I could not hear much at all.

**CHAIR** - Sorry, I will go through that then. The purpose of the inquiry is to look at the legislative frameworks that guide the protective legislation for mental health, particularly the Mental Health Act, the Guardianship Administration Act and the Alcohol and Drug Dependency Act. We are not looking at issues relating to the mental health services or provision of services and that sort of thing; it is looking at the legislation. So we are trying to keep it pretty much to that area. Also if you think that there is something that should; be said in private, in camera, you can make that request if you believe that is important and we can consider that request.

**Ms LANE** - With the media not here I am more comfortable.

**CHAIR** - It does become part of the public record once the report is prepared so it will be available publicly later.

**Ms LANE** - But that is history.

**CHAIR** - Okay, that is all right. We have received your submission and read that but it might be helpful for you to provide an overview of your submission and what you see as the major points in relation to your views.

**Ms LANE** - Essentially the act does not work the way it was intended to. To my mind at least, it is an embarrassment to the people of Tasmania and I would imagine to the Government of Tasmania, be it a Liberal government or a Labor government.

It has been such a failure in fact that the Government have felt it necessary to not only review the current act but also to totally abolish it and write a new act. That in itself is causing all sorts of problems but, as Michelle Swallow was saying, until we see the draft it is very difficult to comment one way or the other on that.

In my submission I did make the point that the select committee was tasked with, amongst other things, inquiring into whether Tasmania's mental health legislation meets worlds best practice in terms of providing adequate protection for the rights and well being of people with psychiatric disabilities and addictions. I basically said, no, it doesn't. That is as simple as you can get - it doesn't.

There have been any number of reports and inquiries into the various State-owned psychiatric facilities that have all been damning in terms of sexual abuse, physical abuse, medical malpractice and medical neglect of patients in the care of the State, be it through the State hospital system or through the Mental Health Service.

If we go down the path of a new act then we are going to see if the new act encompasses the contentious issues of treatment without consent and the dangerousness criteria and we are going to see State-sanctioned abuse without any doubt. That sticks out so clearly.

The other issue in regards to current legislation is that young people in adolescence are not specifically mentioned in the act. That means that they can be subjected to adult treatments. In America the Coulthard Report (?) cited some 142 deaths over a four-year period in relation to restraint and seclusion. One-fourth of those deaths were children.

More recently, late last year I was advised of a situation involving an eight-year-old child who was seriously suicidal and self-harming and there was nowhere for him to go. He was placed in the DPM, which is an adult facility; from there he was transferred to the DPM's HDU, the High Dependency Unit, which has a seclusion room. His behaviour was such that he had to be secluded - restrained then secluded. That did not work so then he was chemically restrained. The current act, when it talks about restraint, only refers to bodily physical and mechanical restraint. There is no mention whatsoever of chemical restraint. So one could argue that the State breached the Mental Health Act.

It is a tricky act because while it does not say that you cannot use chemical restraint it does not say that you can. So we had a situation there where an eight-year-old was chemically restrained.

**CHAIR** - There is no mention of this sort of stuff in the Children and Young Persons Act?

**Ms LANE** - No. This is specifically to do with young people going into inpatient mental health facilities, which do not exist.

**Mr MARTIN** - So there is no statute anywhere that talks about how young people should be treated?

**Ms LANE** - Not in terms of mental health, no. The matter was raised during the 2007 Mental Health Act review process, but those who were in charge of that process chose to ignore the entire process around young people and adolescents and blamed it on a national body for their inaction.

I am here today in my capacity as a mental health consumer but also as a mental health consumer consultant and human rights advocate. I have been working closely with CAMS to try to get a mental health facility for young people and adolescents but it is very much an uphill battle.

As it currently stands, section 92 of the Mental Health Act effectively gives the ineptitude of staff and others an escape clause. We are seeing continuously breaches of the act and no recriminations, no allocation of responsibility and no follow-ups at all, certainly not in the public arena. My own experiences between 2000-08 have been quite



horrific, both in the DPM and other mental health service facilities. In each and every instance the act was being breached in my case.

**Mr WILKINSON** - You are saying it was being breached because it was involuntary?

**Ms LANE** - Most of my admissions have been involuntary, being sectioned. My diagnosis is MPD, multiple personality disorder. That has caused a great deal of confusion within the mental health service because there a lot of people who don't believe it exists, even though it is in the DSM. It also means that a number of our admissions have been under different identities.

**Mr WILKINSON** - When you said that it was illegal, are you saying that it was illegal because it was involuntary?

**Ms LANE** - Yes. I had one voluntary admission, which was interesting because they said, 'You can come voluntarily or we will section you!'

In 2004, during the voluntary admission, I was advised that I was unable to access vegetarian menus, that they didn't exist when I knew that they did because I had used them on previous admissions. It could take up to three days for a meal to arrive for newly admitted clients. On one occasion, once we thought the problem had been sorted out, my meal didn't arrive and I made it known to the duty nurse. He seemed most annoyed, wandered off and came back with a plate full of vegetable scraps left over from someone else's meal and said, 'Here, eat this'. Whilst that may not breach the act per se, it is not exactly the kind of treatment one expects in a mental health facility, being fed scraps like you are someone's pet dog. That happened on a number of occasions. If you complained or became agitated by the situation, you were deemed disruptive and threatened with punishment by being sent down to the dungeons, which is a term we use for PICU downstairs - the Psychiatric Intensive Care Unit. Threats of punishment were often used to coerce patients into complying with medication and behaviour. That, I believe, is an offence under the act but I am not sure of the legality of that. During that same admission after I had been transferred from emergency to DPM I was in such a severely dehydrated state and both my arms were severely lacerated from self-harming that the admitting nurse was unable to take urine or blood samples. She instructed the oncoming shift to do that. Three days later she returned and nothing had been done. No samples whatsoever had been taken.

During that same period of time there was a disagreement over the non-arrival of a meal and in that admission I was in a self-contained room opposite the nurse's station, what we call the suicide rooms. That is where they put people at high risk. I was supposed to be on suicide watch, which means 15-minute observations, and because of my emotional state I used a broken plastic spoon to re-open all the wounds in my arms. Two hours later a visitor arrived, found the bed covered in blood and me in a comatose state and duly reported it to the nurses who had not bothered to undertake the 15-minute observations. So at that stage I was treated. The arms were bandaged but I was treated in a very belligerent manner because staff do not like self-harmers. For some reason they cannot see beyond the self-harm why people do that sort of thing.

**Mr DEAN** - You say some of this comes down to the lack of ability of some of the people working in those areas and/or is it an attitudinal problem to people that are there receiving treatment.

**Ms LANE** - Essentially there is a culture problem that lingers from the days of the Royal Derwent. In all fairness to the Mental Health Services, in my role as an independent consumer consultant, I am engaged by TasCAG, a ministerial advisory group on mental health, and I have been seconded by the Mental Health Service to work on the Beacon Project which is about reducing restraint and seclusion. In terms of culture, the work that we have done with the Beacon Project has been quite phenomenal. I did not expect changes to happen for at least two or three years and they have happened in less than 12 months and part of those changes have been culture and that culture is now moving out of the acute wards and into the general psychiatric wards in the general hospital. So we are starting to see a significant change in culture that is positive and attitudes are more positive now than negative.

But that is not to say that there are not still people who harbour resentment against people who self-harm. I am aware of one young lady who has a borderline personality disorder, amongst other things, and she is often suicidal, often self-harming so the Mental Health Service have now issued a directive that whenever she comes in she is sent directly to PICU, she is stripped naked, put in a suicide gown and kept in seclusion until discharge. That is not treating a person with dignity, respect or bodily integrity, as was the intent of the Mental Health Act when it was originally drafted. They are treating this person no better than a dog.

**CHAIR** - Dannii, I have listened to your story and it has obviously been a very difficult for you and also in assisting other people as an advocate. You made the comment early on that the Mental Health Act has failed to meet world's best practice and to protect the wellbeing of people, so how do you see it could be changed so that it could actually address some of these issues that you have identified? What is the way forward here? We wanted to look at what we can do to avoid the sort of the situation you are talking about and ensure that people are assessed appropriately. Part of it is the culture thing you talked about, which is a separate issue to the legislation. We are trying to look at what legislative framework we can look at for the future that will actually meet the needs of the people.

**Ms LANE** - As Michelle did point out, it is very difficult to give you any definitive answers, when we do not even know what the new act is going to look like. When the issues paper came out there was quite a lot of controversy and anger about the way it was worded and some of the suggestions that the new act might incorporate. Well, at that stage it was a review. They then decided, as a result of the consultation processes around the issues paper, that the discussion paper when it was released indicated there would be a new act rather than the review and, of course, central to that was treatment without consent.

Until that comes into place, until we see the draft it is very hard to make a comment one way or the other, other than to say that this new act would appear to be as bad as the current one at face value.

**CHAIR** - What do you see then as important for the future? Ignoring the fact that we have had a review, in an ideal world what would you see as the best model of legislation to move forward with to ensure that the human rights of people are protected?

**Ms LANE** - 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.

I know Anita Smith from the Guardianship and Administration Board has suggested that we don't even need a new act because the majority of the amendments that were proposed in the discussion paper can be dealt with under the Guardianship and Administration Board's current legislation.

Because I am also involved with mental health quality and safety as an independent consultant, in that role I often see policies and procedures, reporting and so on. It is quite clear that the majority of Mental Health Services staff are not aware of their responsibilities under the current act. They simply do not understand it. When you look at it that is quite understandable because it is so riddled with ambiguities and loopholes and it is almost impossible to make any sense out of it.

**Mr WILKINSON** - Can you give us an example of that, Dannii, for my education?

**Ms LANE** - Let me think; there are so many.

Harking back to young people and adolescents in terms of restraints and seclusion, the act talks about restraint as being physical and mechanical. Now when you talk to anyone in Mental Health Services they say that they wouldn't use mechanical restraints, they would not even know where the shackles are. So all they are doing is using physical restraint, and the average episode lasts two to three minutes.

There are issues with patients being transferred from DPM down to PICU.

**Mr WILKINSON** - PICU is what?

**Ms LANE** - PICU is the Psychiatric Intensive Care Unit. DPM is run by the Royal Hobart Hospital, PICU is run by the Mental Health Services and the Royal Hobart Hospital seems to have an issue about combining; they don't want to be under the Mental Health Services so there are all sorts of problems there but that is apart from the act.

So it means if someone is being transferred down they have to be held to be guided and that constitutes an act of restraint, which then must be reported and recorded. In PICU they might handle someone five or six times a day and the episodes might last one minute to two minutes and they have to report and record every instance of those.

In relation to seclusion there are four hours. After four hours there must be a medical review but there is no mention of young people. So, as I have said before, young people would be treated as adults when in fact it has been proven globally that restraint seclusion practices on young people can be lethal. Aside from that, they can be

extremely traumatising and the majority of people who have been diagnosed with a mental illness will also carry trauma from early childhood, more often than not sexual abuse but not necessarily just sexual abuse. There could be other forms of trauma and so that manifests in later life. The evidence is saying, quite clearly, that even trauma in the second term in utero through to three years of age can trigger schizophrenia or bipolar affective disorders in young people. So the Mental Health Act currently doesn't make any allowances for young people at all and there have been no amendments to it because basically the number of young people at any given time coming through the system who need in-patient care is very low. So the Government has always said they can't afford it.

**Mr DEAN** - Just looking at the young people, in your research have you looked at other jurisdictions in Australia that do have a component in there for young persons?

**Ms LANE** - I've done quite a lot of research through the Beacon Project on Australian and international trends in relation to young people, restraint and seclusion and other areas. The overwhelming evidence is that young people and adolescents up to the age of 17 should not be restrained or secluded, but there will always be circumstances where, whether we like it or not, that has to happen. In the case of much younger people, chemical restraint of young people is banned in many countries. Our act does not allow for anything at all. I am currently in the process of developing, in conjunction with Narelle Butt and Lorraine Bell, who is the project officer of Beacon Project, statewide policy and procedures governing restraint and seclusion. I have pushed to have included specific time frames for young people if they have to be restrained or secluded.

**Mr DEAN** - But there's no other State that you've looked at that has a -

**Ms LANE** - South Australia is probably the leader in terms of restraint and seclusion, new strategies and new alternatives, in that they also include how to deal with young people and children and adolescents. In America there are a number of jurisdictions that have taken on board very seriously the treatment of young people and adolescents within mental health legislation. We are so far behind in that regard it is almost an embarrassment.

We spend millions of dollars on mainland football clubs, upgrading sports stadiums, supporting industries that could be considered of dubious benefit to the State, but the Government adamantly refuses to fund the provision of a specific mental health in-patient unit for young people. If you are a forensic patient at Ashley you can be transferred to the Wilfred Lopes secure mental health unit and be treated there because the act allows for that. If you're an involuntary patient you can legally be transferred to Wilfred Lopes but essentially it is still an adult prison. Transferring a young person there, whilst it might be legal, is morally wrong and the child will suffer extreme traumatisation.

So, how do you deal with the current act? I don't know that you can. I will give you one example. Seclusion under the act means a person confined alone in a room where the doors and windows are locked from the outside; that's been the standard definition of seclusion since the act was enacted. Places like Launceston's Ward 1E and the DPM in Hobart have high-dependency units and within those units they have seclusion rooms. There was some concern that people who were in the high-dependency units were being inadvertently secluded, which was a breach of the act, so the Solicitor-General was asked

to look at the situation. He came up with a definition of 'room' which he said could be broadly interpreted to mean any collection of rooms or compartments. That satisfied some people but in the process it now means we have staff in the DPM breaching the act almost every single day. They do not mean to but they know they are doing it. The Solicitor-General's advice was given without actually examining any of the circumstances around the various sites. The act just does not have enough flexibility to provide for specific locations for mental health facilities and for specific circumstances. It is just not flexible enough and because it is so riddled with ambiguities it is very hard to determine what is and what is not something. Going back to the definition of 'restraint': is it physical or mechanical? We do not use mechanical but we are using chemical restraint and, like I say, the act does not say you can use it but it does not say you cannot use it.

**Mr DEAN** - Just on the flexibility of places for young people, do you think that the review is covering that?

**Ms LANE** - The review for the new act?

**Mr DEAN** - Yes.

**Ms LANE** - No, they are not, they are refusing to discuss the matter and I did make that point in my submission. I am working with CAMS fairly discreetly in my private capacity. CAMS have certain needs and they cannot have them met. As an interim measure, DPM was able to secure funds from a variety of sources and they converted part of their high-dependency unit suites. One seclusion room was converted to an art therapy room. Another room was converted to a sensory de-escalation room. These involve all sorts of early intervention techniques - painting the walls with beach scenes and having music piped through and sun deck chairs and so on. They still retain one room as a primary seclusion room. Young people are going there because it is not safe if you have an eight-year-old, for example, to leave them in the open DPM ward because it is dangerous.

We had admissions in 2000 and 2001 and in one of those admissions we were sexually assaulted. We do not know who by because there are no uniforms. It could have been a patient or it could have been staff. I know that the staff at that point in time were sedating patients because the staff did not like being woken up during the night.

**Mr DEAN** - Are you aware of whether or not there is anywhere in this State where a young person, say a 15-year-old who has a difficulty in relation to a mental problem, can be placed? Is there any suitable place?

**Ms LANE** - If they have been convicted of a criminal offence or are on remand they go to Ashley. Ashley does not have the specific requirements for these people who have very special needs, so what happens is that they are sent to Wilfred Lopes. That is essentially an adult mental health prison. It was only commissioned in 2006 but already in design terms it is obsolete because no-one thought sufficiently far ahead. However, it does have what we call 'swing units'. These are accommodation units that can be converted very quickly so that they are isolated from the rest of Wilfred Lopes and so young people or elderly frail people who may have committed an offence can be housed there relatively safely.

If you are not a forensic patient and you are an involuntary then you can be transferred to Wilfred Lopes as a last resort or sent to the DPM, where you would go into the HDU units. If you are a young person with a mental illness and you are not an involuntary patient and you are not a forensic patient, you have nowhere to go. There are two options: one, if they are young enough you can put them in a paediatric general hospital ward, which traumatises all the other patients because of the seriously disturbed behaviour which these young people exhibit. Again, you do not have immediate access to specialised care which these people need. The other option is to send them into DPM. There is nowhere for them to go and the act has totally ignored young people with a mental illness. We are seeing more and more people coming into the system with mental illnesses. The statistics that are being released by the Australian Bureau of Statistics and other sources are all indicating that there have been marked increases in the episodes of sexual and physical abuse of children and the neglect of children. These are all manifesting now in their early puberty/adolescence as mental illnesses so they are coming into our systems and we are not prepared because we do not have the facilities to deal with them. The act does not give us any guidance as to how to deal with them. On top of that, we now have increasing numbers of refugees coming from Ethiopia and Somalia. It is the children we are starting to see because they have been traumatised by what they saw happen to their parents. We are not even geared up for that; the act does not allow for it. We are developing policies and procedures that say, 'If you have someone with an ethnic cultural background, we will provide an interpreter service. We will provide a support person'.

Just recently I reviewed the sexual safety policy of Mental Health Services. That was a shameful paper and had to be completely rewritten. Now the clinicians are arguing, 'It's 50 pages long. Why does it have to be so long?' We are making some advances in policies and procedures but we are hamstrung by the current act. That is what it comes back to. As Michelle Swallow said earlier, I question this committee sitting so early when to be effective you should be meeting after the new act comes into force.

**Mr DEAN** - It is probably too late then.

**CHAIR** - We could be waiting for another 12 months.

**Ms LANE** - It's not impossible to make amendments. Wilfred Lopes was already built and they didn't have any legislation protecting it. They didn't have resources, the people, the money and they especially didn't have the time to come up with a new act that was specifically around forensics, so they amended the current act, which has been a nightmare in trying to separate the two. I know the people involved in that and they have basically reinforced that view. When the draft policy comes out that will be the perfect opportunity for a lot of people to pull it apart and decide if it is going to be good or bad. My belief is that it will be bad for consumers.

**CHAIR** - If that is the case, what the best thing to look at in the future, so that we are doing some of the work that could guide the future?

**Ms LANE** - The two committees involved in developing the new act - reviewing it and developing the new act - had all the best intentions but they are still thinking twentieth century methodologies and we are now in the twenty-first century. If you look at any number of countries around the world, in America, for all its faults, some of the states have some of the world's best practices in mental health care and management. The EU

has countries, particularly Italy, that are so far advanced. Even New Zealand puts us to shame. South Australia, amongst all the Australian States, is probably leading the field in mental health legislation, in my opinion. We are coming up with stuff that really is obsolete and the sort of thing you would see in Stalinist Russia. As consumers we are told that this new act is in our own best interests, but having the police knock down your door, forcibly drag you out of your bed, handcuff you, put you in an ambulance, send you to Emergency is not in our interests. Then they section you and start filling your head with all sorts of potentially dangerous and lethal drugs under the treatment without consent provisions. That is not modern mental health care, that is abuse of the worst possible kind and it is a breach of international law. But that is what this Government wants to do.

**CHAIR** - We are running out of time. Time does pass very quickly in here.

**Ms LANE** - Yes, unfortunately. I was not sure how the procedures would go so what I did do was write up what I thought would be a verbal presentation of specific issues that I have had to endure as a client under the Mental Health Act. I will leave that with you. It does relate to breaches of the Mental Health Act of which you have my original document.

**CHAIR** - Yes, thank you. Thanks for your time and for your submission.

**Ms LANE** - Is your work going to be in vain, given that you are dealing with the current act and we are in the process of developing a new act which will be, I imagine, quite different in terms of content and legal aspects?

**CHAIR** - Under our terms of reference the role of the committee is to look at the legislation and the three major bodies that guide this area. We will report and make recommendations. That is all a committee can do. It is up to the Government then to consider the report and the recommendations and to act as they see fit. If there is a strong body of evidence to suggest that we need to really review all three in entirety, whether it be a new mental health act that comes out in this next sitting of parliament or whether we are still waiting for that, that is up to the Government to decide. But if we have a lot of evidence then hopefully they will take it seriously and think, 'yes'. Both the previous Attorneys-General and the current Health minister have indicated that they are aware that these other acts do need review as well. So hopefully there will be a constant comprehensive review in the future. But we cannot actually force that. We can just make recommendations. So hopefully it will not be in vain.

**Ms LANE** - I think in a nutshell basically the current act is not properly understood by the people who are obligated to work within it. The way it was written allows for the act to be regularly abused, both unwittingly and knowingly. At the same time there is no accountability, no transparency. In a nutshell, I think they are the issues that this current act faces. All the other stuff sort of flows from that.

**CHAIR** - Thank you for your time.

**Ms LANE** - Thank you for the opportunity. I hope I have given you something worthwhile.

**THE WITNESS WITHDREW.**

**Mr MARTIN GIBSON**, TASMANIAN COUNCIL OF SOCIAL SERVICE (TasCOSS), WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

**CHAIR** (Ms Forrest) - Welcome. The purpose of our select committee is to look, within the terms of reference, at the legislative frameworks that underpin the protective legislation for mental health. We are very well aware, as I am sure that you are, of the current review of the Mental Health Act. It is not to undermine that in any way, it is to look at a broad framework for the future. We have received and read your submission and we ask you to give an overview and to pick out the important points as you see them.

**Mr GIBSON** - Ours was a brief submission as we felt that there are other organisations in a better position to make detailed submissions in relation to the way forward in terms of the mental health legislation in Tasmania. TasCOSS felt that it was important that we did make a submission in relation to this process, given that we are the peak body for community organisations some of which are providing services to people with mental illnesses and bodies that advocate on behalf of people with mental illnesses. Also, we represent Tasmanians who are on low incomes and suffer some form of disadvantage. Clearly people with especially severe psychiatric illnesses are some of the more vulnerable members of our community.

The bottom line of our submission is that clearly there are some deficiencies in relation to current mental health law in Tasmania. We are aware that there is a review in relation to the Mental Health Act. Because it is limited to the Mental Health Act, the possibility of broader, all-encompassing, capacity-based legislation related across the field of disabilities is an innovative proposal that we were very interested in. Our concern is that it would seem from our perspective to be a considerable project. At the time of making the submission we were quite confident that the draft bill being proposed would contain a number of safeguards that would be very useful in addressing a lot of the deficiencies with our current legislation. We would like to see these safeguards up and running and get them in place and once that is done perhaps we can step back and determine whether there is broader project in relation to looking at what is the role of the Guardianship and Administration Act, the Alcohol and Drug Dependency Act, Mental Health Act. Is there capacity to merge those pieces of legislation, a chance to look at capacity on its own and to merge some of the administrative structures? Our preference, as we say in our submission, is that we would like to see the review completed to let us get on to the next project.

We have not been close to the Mental Health Act review process. We have had some conversations with members and others about understanding what is happening there. We have not seen the draft bill in its current state. We have some concerns with the global financial crisis and the impact on the State Budget that the funding may not be available for the implementation of a new Mental Health Act, which in itself is a considerable and expensive project.

We are perhaps not prepared to make a recommendation at this point and I imagine the select committee through this process will be well informed to make a recommendation as to whether it is appropriate to continue with this current process and try to get a new Mental Health Act in place. If it looks like we are not going to get the safeguards up that we need as part of this current legislation or that we are a long way from completing that process or it is unlikely that the funding, even if the act is passed, that we are not going to



be able to implement it for a long period, then perhaps it will be time to step away and ask whether we should be looking at a broader process.

**CHAIR** - We could have a bill, and I personally was assured that a bill would be before us in this sitting of Parliament, which may or may not happen. Even if there is a bill, we have no guarantee it will be proclaimed for several years, as happened with this Mental Health Act.

**Mr GIBSON** - Yes, it happened last time.

**CHAIR** - It took two or three years before it was proclaimed. None of us has a crystal ball, and that makes it hard to know what is going to happen. Are you more of a view to suggest that if it looks likely that it will be a number of years before we have an act proclaimed and resourced according to the State Budget, it would be better to move on with a more comprehensive review in the interim?

**Mr GIBSON** - Yes. It is a difficult judgment to make as we do not have a crystal ball. How many years away does implementation of a new mental health act and new safeguards have to be before we think it is worth starting a new process? It is hard to say. It is something that we did not really address in our submission. You have had a number of submissions in relation to these issues.

I suppose our bottom line is in relation to the safeguards that we would like to see in mental health legislation in Tasmania and we think there is considerable potential for those safeguards to be introduced through the existing process. A number of those, I understand, were going to be included in the draft bill and some others are not part of the current process. I am not sure if you are interested in my talking briefly about what we would like to see.

**CHAIR** - That would be helpful. There have been suggestions that a mental health act in itself is perhaps not world's best practice in relation to the Human Rights Convention and Australia's ratification of that in 2007. Certainly in one state in Canada they have moved toward a capacity consent act rather than a mental health act and the UK have gone to a mental capacity act but they still have their Mental Health Act sitting beside it. There are varying models being tried and I am keen to hear your views on what are the integral and important parts needed to meet the world's best practice and ensure that the well-being of people is respected.

**Mr GIBSON** - Yes, and I suppose we can reserve judgment on how we should be presenting at the moment as mentioned earlier. Perhaps in an ideal world, yes, we would like to see a merged act and a focus on capacity, but our practical question at this time is: 'Are we better to proceed with what we have got and then move to that stage later on?'

I suppose the concern is that if we were to abandon our current process in favour of a broader process the risk is that the situations that I am about to describe will continue for a number of years and that these protections will not be in place. There are some opportunities to provide these through the current process.

One of our first concerns is in relation to the role of the person responsible. The person responsible is actually a concept that is included in the Guardianship and Administration

Act rather than the Mental Health Act but it is, I understand, the most common way in which people in Tasmania are provided with treatment without their consent. Where a person presents and the judgment of the medical practitioner is that that person has a mental illness, requires treatment and is unable to provide an informed consent then the practice is to identify a person responsible - often a relative - to provide that consent on the person's behalf and say 'I have got Martin here, he is not well, you probably understand he has a mental illness, we think he needs x treatment, we do not think he is in a state whereby he can make that judgment on his own. Are you willing to provide that consent on his behalf?'. Often the situation is that the person on the end of the phone will say, 'Yes, I am prepared for you to give that treatment' and treatment occurs. There are no orders put in place. There is no need for an order. The substitute consent has been provided by the family member, friend, whatever.

There are some people who like that model. There are some carers who advocate strongly in favour of that model. However, concerns around that model are that the person responsible is not always someone who is intimately connected with the person with the mental illness. Apparently there have been cases where the connection has been very remote; for example, a former flatmate who has not seen the person for five years. Those types of scenarios have occurred.

**Mr DEAN** - Surely there would have had to have been a legal guardian or a legal parent for them to make that decision on behalf of another person.

**Mr GIBSON** - No.

**Mr DEAN** - Wasn't it under the act?

**Mr GIBSON** - Unfortunately I do not have a copy of the act in front of me.

**CHAIR** - Is it Guardianship and Administration Act?

**Mr GIBSON** - Yes, Guardianship and Administration Act. It is probably easier for me to find it in here.

**Mr DEAN** - I did not mean to put you on the spot. I am just saying -

**Mr GIBSON** - No, no, it is entirely appropriate. Of course it is an extensive set of provisions in relation to who a person responsible can be, but you can soon see it says 'where the person is of or over the age of 18 one of the following persons in order of priority', so first a guardian then a spouse, a carer but in the last resort a close friend or relative of the other person, which ideally would indeed be a close friend or relative but we understand that there have been situations where it's been quite difficult to locate a person responsible and a judgment has been made. They'd seen a name on a patient file and said 'Okay Richard Smith gets a mention here and there's a phone number for him; let's call Richard' and yet the proximity between Richard and the person for whom treatment is proposed is actually quite remote.

So, there is that concern but there is also the concern that even where the person is a family member or is well known to the person with the mental illness, that creates a very difficult situation for the person being asked to consent to treatment, especially where the

person with the mental illness is refusing treatment. It creates tension within families; carers can have problems. If, say, I have a mental illness and I don't want the treatment, but my parents consent to that treatment, it can clearly create strong tension within families. The third issue is whether family members, relatives or carers have the expertise to make that judgment. Clearly, often they do; they have a good understanding of the person, they understand their illness, they understand treatment options, they understand the symptoms of what's occurring for that person and they're in a position to make that judgment; but not always. I think you'd appreciate that it is a complex medical world that we live in and the range of new drugs being made available in relation to mental illness can make it quite difficult for the person in the street to make a judgment as to whether that's an appropriate treatment or not; they're not medical practitioners.

Our position would be that where someone is unable to provide consent in relation to medical treatment it should be an independent specialist tribunal making that decision rather than family member, friend or person in the street as is the current situation and, as I understand, that is the most common way that people receive treatment without their consent in Tasmania.

**Mr DEAN** - Chair, if I could just expand; Martin, is there much evidence available to show that the current position of a relative, friend, et cetera has not worked? Are there many examples of that - to your knowledge, basically, I'm not meaning to put you on the spot.

**Mr GIBSON** - I am probably not in a position to tell you how much evidence there is. In the Mental Health Act review discussion paper on page 17 it talks about the responses -

**CHAIR** - It says a number of responses, doesn't it?

**Mr GIBSON** - received in relation to the issue. I mean, there is some summary there of the consultation in relation to that issue but no, I am not in a position to tell you how often that happens.

A second major concern with current legislation is the lack of review in relation to mental health audits, both in relation to detention and treatment. It is probably a particular concern in relation to treatment decisions made under the Guardianship and Administration Act that under current law a medical practitioner can contact the guardianship board via telephone and request authorisation for emergency guardianship in order to provide treatment to a person. The basis needs to be that the person does not have the capacity to consent to the treatment. That is the entry point to the guardianship act.

**CHAIR** - This is with physical and mental health issues?

**Mr GIBSON** - I am confining myself to mental health issues here. So the practitioner makes a call: 'Martin is with me now. He is clearly psychotic. He is not in a state to consent to treatment. I think he needs treatment. Will you authorise that for me?'. 'Yes, we will'. Review of that decision may not take place for up to 28 days. Clearly that is a very serious decision. It is a decision to treat somebody without their consent. Apart from that kind of telephone call authorisation, there is not necessarily any review of that decision.

**CHAIR** - Does that mean treatment can continue for that 28 days without that person's consent?

**Mr GIBSON** - Yes, which is a serious concern. Similarly there is no review of general guardianship decisions in relation to treatment. They can have a duration attached to them, for example that treatment can proceed for three months, but there is no prescribed period of review for guardianship orders. Similarly, in relation to detention, which is under the Mental Health Act, there is not any regulated review generally up to the 28-day mark. The average length, I understand, of continuing care orders is about 13 days. So the suggestion is that most people who are put on orders under the Mental Health Act never actually get to the point of review by the Mental Health Tribunal. Sometimes that is intentional. Orders are discharged at the 26-day or 25-day mark because practitioners do not want the inconvenience of the tribunal process. They think it is simpler for everyone concerned not to have to be engaged in that process so the order is discharged prior to the 28-day mark. It would seem that, yes, the tribunal is perhaps not performing its intended role as reviewing Mental Health Act orders because it is a low-percentage of orders that actually ever get to the tribunal under the current system.

**CHAIR** - Do you see that as a model that is there for the benefit of the medical staff, so it is easier for them to initiate treatment, and continue treatment without it being checked, even though it might well be the best and most appropriate treatment? I am not saying that it would not be. I am sure in the majority of cases, if not all, it is the best treatment but there is no avenue for review and by the time the 28 days ticks over it is easier for the medical profession to say, 'We have this person sorted out for now. We will remove that order' or remove their treatment or discharge them from the system.

**Mr GIBSON** - I am reluctant to speak here on the thinking behind a 28-day order but certainly I think it is more practical perhaps for practitioners. It is easier for them to operate within a 28-day framework and they do not need to present decisions for review within a short period.

**CHAIR** - You could argue that some of the antipsychotic medications take more than that time to be truly effective and assessed as effective. Are you aware of cases where the patient might have been discharged without the medication because of that 28-day program and without necessarily having that full assessment period?

**Mr GIBSON** - No. In this case we are talking about whether people are detained in hospital or discharged from hospital. I think there are medical practitioners who would argue that they do not want to come before a tribunal before that point because sometimes it does take that long to determine what is happening for a person and to then to determine what is the appropriate regime for that person.

From a rights perspective it would seem that it is one of the very few occasions in which you can detain someone where they have not committed a criminal act. So it is a very serious order that you can detain someone in hospital on the basis of their mental illness and their danger to themselves or others. Clearly the major safeguard for that decision is review by an independent tribunal. But the concern is that if that review does not take place in the majority of cases then how effective is that review. My understanding of the draft legislation being proposed was that one of the key features of that legislation was early review of orders.

**CHAIR** - Do you have any idea of the time frame that was being suggested?

**Mr GIBSON** - I think it was 10 days. Interim authorisation within three days. Again, that would be like a phone call to the tribunal and then within seven days after that period there would be a full hearing. So if the average duration of detention orders, continuing care orders, is 13 days then you would hope that at 10 days you are getting most of the people who are subject to orders.

**CHAIR** - Is this one the resourcing issues you talked about? If every order is reviewed within 10 days that means pretty much all of them will need to be reviewed by the tribunal, so they are going to have a lot more hearings than under the current model.

**Mr GIBSON** - Yes. It has a serious resource implication as proposed in this discussion paper as a new model of review in Tasmania. At the same time, yes, it is a seriously stronger safeguard.

**Mr DEAN** - With the original decision to provide that treatment and to keep that person in a controlled position to do that, if that process is robust enough in the first instance why do you need then to review it as often as you are saying it should be reviewed? We have a robust and proper system, and doctors and medical people involved in that initial order or initial discussion to provide that treatment. Why would you need to review? Because it has been done for the benefit of the patient or person. I do not like 'detention'; whilst they are being detained there is probably a nicer word for it.

**CHAIR** - 'Held captive' would you prefer?

**Mr DEAN** - They are simply being provided with medical treatment and that medical treatment is better provided in situ.

**Mr GIBSON** - They do not have the option to leave and I suppose that is the most important point. That is why it is most commonly referred to in those terms. What is the process in terms of that medical decision-making, the starting point?

**Mr DEAN** - I was of the belief that there was to be an assessment conducted at the time they presented. If they presented to a hospital there was to be an assessment made there and then as to whether or not they should be detained. That was an issue brought forward to me where people and parents have complained that that assessment has not been robust enough and they have been turned away.

**CHAIR** - The decision by a medical practitioner, not the tribunal?

**Mr DEAN** - I am talking about medical practitioners and the hospital system.

**Mr GIBSON** - It is clearly another issue and it has been suggested that this is perhaps a resource issue, that emergency departments and departments of psychiatric medicine in particular just do not have the capacity to meet the demand in terms of people who are presenting to emergency departments for medical intervention. Perhaps, as a result, the bar is raised fairly high in terms of who gets in and the suggestion from carers, police,

and support workers is that there are a number of people who would benefit from an admission to that part.

**Mr MARTIN** - I was dealing with a case last week where the written Royal Hobart Hospital policy is not to admit patients who are primarily suffering a personality disorder for whom a brief period of time in hospital is unlikely to produce any therapeutic benefit unless they fall into one of the five major categories of mental illness. So, therefore, someone who has been diagnosed with a personality disorder, who can be having quite an impact on himself and those close to him and his immediate community, has been turned away. What we are hearing is that it is simply a resource issue.

**CHAIR** - This covers voluntary admissions as well. Not involuntary?

**Mr MARTIN** - No, it is voluntary.

**CHAIR** - Yes, so there are problems with voluntary. The Mental Health Act narrowly relates to people on involuntary orders. That does not apply to a person with a voluntary admission. Even that situation that Terry describes does not fall under the Mental Health Act because that is for people on involuntary orders, isn't it? It is not for people who want admission and they cannot get it. It is a different situation.

**Mr GIBSON** - There is probably a point earlier than that where people are restricted from accessing the system on the basis that to be admitted to a mental health facility in Tasmania you need to have a recognised mental illness. Personality disorders are not recognised under Tasmanian law.

**Mr MARTIN** - I think they recognise it as a mental illness but not one of the five major categories, which is being used really as an excuse, supposedly because of lack of resources.

**CHAIR** - Shortage of beds and that sort of stuff. And staff.

**Mr MARTIN** - Yes, and staff. Bringing up the subject of resources, TasCOSS would have done their budget submission to government by now. Have you called for greater resources on mental health?

**Mr GIBSON** - To be honest, I am not sure that we did in the budget submission. What we have asked for in our submission this year is greater focus on early intervention programs for mental health services. We have not framed it so much as a request for increased funding but for an increased focus on early intervention and promotion activity so as to reduce the demand for acute-care services.

**CHAIR** - Do you want to go further with those other points?

**Mr GIBSON** - A third concern is quite basic. The current Mental Health Act envisioned that treatment plans would be used on a standard basis for people who were subject to orders under the Mental Health Act. The practice is that the Mental Health Tribunal very rarely see a treatment plan and that when they do, apparently it is very scant on detail in terms of medication provided, all the symptoms that the person is presenting with or what the kind of long-term care options are. The proposal in this discussion paper was that it be

mandatory for treatment plans to be presented and for a mental health treatment order to be made. No treatment could be made in the absence of a treatment plan. Our concern is that in the absence of any legislation to that effect we'll continue with the situation where it's very difficult for the Mental Health Tribunal to make an assessment about the appropriateness of an order where there isn't any obvious treatment plan.

**CHAIR** - Does the treatment plan include the treatment that the patient has received prior to the hearing as well as what is planned for the future or is it more just a future plan?

**Mr GIBSON** - My understanding is that it would include what's been provided to the person since they've been admitted on this occasion, and what is proposed for the duration of the order.

**CHAIR** - So, just to clarify that, if the treatment plan is presented to the Mental Health Tribunal they would have all the history since that patient's admission -

**Mr GIBSON** - I am not sure that it would necessarily include all of the history.

**CHAIR** - We have heard some evidence that there is no requirement for the medical practitioner to provide a reason for the initial order to the tribunal when it's going up for review of the order.

**Mr GIBSON** - I am not sure; I can't comment on that.

A fourth issue, and I'm sure you've heard other evidence in relation to this, is that there is a lack of clarity in relation to capacity issues. There are perhaps two key issues. One is a concern that there are occasions on which practitioners are providing treatment to people without their consent under the Guardianship and Administration Act on the basis that they are incapable of providing consent but that that judgment is actually based on the fact that the person has refused treatment. So, it's not necessarily based on a proper test of whether the person is capable of understanding the nature and effect of the treatment or not; it's actually based on the fact that the medical practitioner is saying, 'Well, I think that you need this treatment; you have a mental illness and it would appear that you need treatment; you are refusing the treatment and that, to me, is an indication that you're not capable of making a decision as to whether you need treatment or not.' The concern is that there is some inconsistency, perhaps, among practitioners in relation to the application of the capacity test. 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.

**Mr MARTIN** - How do you think that can be improved?

**Mr GIBSON** - If there were a much clearer focus in the act or a distinct piece of legislation - for example, if you had mental capacity legislation - with a much greater focus on capacity as an issue, and if it was very clear to practitioners that the first step in any intervention is that assessment of capacity. The first step is assessing whether or not a person is capable of making an informed consent. And there are separate pathways involved. In effect, sometimes a pathway may be very similar but there are separate

logical pathways involved as to whether a person has capacity or not. But if they don't have capacity then some kind of order is required. At the end of the day, an independent tribunal is going to have to sign off on the treatment for that person. 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.

**CHAIR** - That can happen with physical illness too, though.

**Mr GIBSON** - Yes. It is interesting that we only apply that test in relation to psychiatric illness.

**Mr MARTIN** - The view has been put to us today that just having the Mental Health Act is discriminatory because you do not have the cancer act, an MS act or a diabetes act.

**Mr GIBSON** - Or an acquired brain injury act.

**Mr DEAN** - Another position which was put us this morning by an expert in this area was that the rules and conditions to provide treatment assessments are so hard that some psychiatrists simply could not be bothered going down that track and are not authorising the treatments that need to be authorised because of the rights of people and the capacity side of things et cetera. Some psychiatrists try to avoid it. What would you say to that?

**Mr GIBSON** - I think the determination of mental health law is perhaps at the cutting edge of the discussion of rights, medical practice and ethics within our community. I think these are genuinely very complex and interesting debates about to what extent we protect rights and facilitate medical intervention. I think there is a range of perspectives among medical practitioners as to the value of the rights framework. Have we gone too far? There are other practitioners saying you frame your practice around these issues and they are quite easy to adapt to.

**Mr MARTIN** - Does TasCOSS share the view on whether we have gone too far or not in relation to the rights?

**Mr GIBSON** - I am not sure that I want to make a comment about that other than to highlight the issues in relation to capacity. The determination of capacity needs to be the first step. My other comment is that under current Tasmanian law there is no capacity 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. In some other Australian acts - I think Victoria is an example - there is a provision for reasonable refusal, but you can still be given treatment against your will. You may capacity to make the decision and say, 'Look, I am capable of making this decision. I do not want that medical treatment because it makes me unable to function at work, results in significant weight gain, causes me pain' or whatever, but the tribunal can still make a decision and say, 'Yes, but



unfortunately when you are in this condition you are a significant danger to people around you and we are not willing to countenance that. We are sorry but you are going to have to have the treatment'. In Tasmania that discussion does not take place simply. If you refuse, a medical practitioner can simply say you refused, but you should have the treatment and then treatment can be provided.

**CHAIR** - This is going back to Victorian times where the doctor was seen to know best and no-one ever questioned a doctor's opinion or view. It has taken a while even for patients with any medical condition to challenge a doctor's view. There were times in the past when you would not even seek a second opinion. People will now seek second opinions but is this a gradual process and no section of the community is always right on these matters?

**Mr GIBSON** - I should qualify that statement as, at the end of the day, under section 32 it is the Guardianship and Administration Board that makes the decision. It does go to the board for determination so it is not just the practitioner making the determination. There is a lot of power in the practitioner's hands in terms of recommending treatment.

**Mr DEAN** - Under a lot of other legislation there is the right of appeal if something is ordered. In this you do not.

**Mr GIBSON** - I imagine that you have evidence in relation to this: under current Tasmanian law there is no provision to make advance directives in relation to psychiatric treatment. Provision for advance directives, whereby when I am well I can make provision for treatment options and other options when I am unwell, would be extremely useful instruments in terms of enabling appropriate treatment and care and restoring independence and power to people with a mental illness who are likely to suffer periods of incapacity. There are some examples within Tasmanian law where we use a type of advance directive. We have a power of attorney for situations where older people or people who are likely to suffer enduring incapacity, when they are capable with a solicitor are able to make an agreement and give decision-making power to a designated person. When they not capable of making a decision that person manages their financial affairs and they can make decisions in a range of areas. It is not a concept that is not without precedent in Tasmanian law. It is a bit tricky with regard to mental illness because the periods of incapacity are episodic so it is not a continuing condition.

**CHAIR** - Could the enduring guardian be used in that role?

**Mr GIBSON** - Yes, it is a similar model.

**CHAIR** - Episodic care is the issue. I am my mother's and father's enduring guardian, more for their physical health should they need decisions made when they are incapable later in life. I am not aware of it being used in a mental health setting. Do I relinquish my rights as their enduring guardian once they are well again in a mental health setting?

**Mr GIBSON** - Yes, it is trickier in an episodic situation. There are people who suggest that it could be quite simple; you could go to a GP, the GP makes an assessment that you are capable, you set out what happens when you lack capacity and that is what happens. From a medical perspective, does the doctor determine what value to give this document when the person presents to the practice? What if it was made six years ago and in the

meantime there have been medical advancements? What happens when they are in their hospital bed and they agree to having a drug when previously they have said no? What happens when we say we have a new form of there drug that does not make you fat when you take it?

**CHAIR** - That is the same with any medical treatment. Those concerns do not just apply to mental health.

**Mr GIBSON** - No, clearly. Without wanting to go into specific detail, if we want to go down the path of advance directives it requires a significant amount of work but the absence of the capacity to make an advance directive under Tasmanian mental health law is a concern. It seems to be an exciting proposal that could mean significantly improved quality of life for a number of people.

**CHAIR** - Thank you for your time and your submission.

**THE WITNESS WITHDREW.**

**Mr PATRICK CHARLES CARLISLE, RICHMOND FELLOWSHIP OF TASMANIA,  
WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.**

**Mr CARLISLE** - Probably I could start with just a general statement about where the Richmond Fellowship comes from. The Richmond Fellowship turns 50 years of age this year. It was started in Surrey in 1959. Hence the name Richmond, from that location, and 'fellowship' was a group of people who got together. There is no church-related connotation there. Since then, Richmond Fellowship has spread around the world to over 60 countries and is represented in each State and Territory of Australia. Each State and Territory is an independent body in itself, run by local people. In our case, we are an incorporated body under the Associations Incorporation Act of Tasmania.

We've been in Tasmania since 1984 and have been operating as a service since 1987. We celebrated 21 years last year with the recognition that we now provide 54 placements for residential supported accommodation and recovery services across the State; we have 19 outreach packages along the north-west coast from Port Sorell to Stanley, and we also run out and about programs in the Launceston and Hobart areas. Again, we touch the lives of probably about 80 different people each week in those locations. We have across-the-State coverage and we certainly have an interest in mental health as our primary service delivery area.

The dominant part of my submission certainly didn't address what the terms of reference were looking for, which was comment on the acts. The submission says that to have the best legislation will not necessarily deliver the best service. We need to look at both the legislation and the way that the legislation is interpreted and delivered as a service delivery to our consumer base in Tasmania. That's where a lot of my submission work came from. Having listened to the previous witness giving his evidence I certainly can see where you're coming from about the areas that you certainly might comment about.

My submission drew from the national standards on mental health services, which very clearly say that one of the most important things is equitable access to appropriate mental health services when and where they are needed. You spoke about the incident of a person going into hospital requiring some service but because they are a voluntary patient for whatever reason they are turned away. It may have been resource implications. There is no onus in that particular situation for the person to get that service. We sometimes find that frustrating for our consumers; trying to get access to those services is not necessarily acceptable because of the resource issues. These are the conundrums we face with voluntary patients. In our case, because they are living in the community, most of our clients are voluntary patients in that respect. Only one or two of them may have an order against them, a community treatment order which will ensure that they maintain their medication regime. That is usually the only condition for which we can assist those people, assisting them with their medication regime by reminding them. We cannot force them to take the medication. That can only be done by a health practitioner, like a nurse or a doctor - somebody who is authorised under the Mental Health Act.

**Mr MARTIN** - Quite a few of your residents are ex-residents of Willow Court. Is that right?

**Mr CARLISLE** - No. We have a number who were initially taken from Willow Court in the old Royal Derwent days, and we set up our service in Rokeby, which originally started

with 10 residents and now has 12. Of the original 10 residents there are only four residents still in that service. Most of them have now moved on to independent living, something that was not envisaged by some health practitioners - that they would be able to reach that point. Two years into the service an elderly gentleman moved back to the north-west coast. Unfortunately he died last year at the age of 79 but he had the last two years living in close contact with his extended family in the north-west area. This was something that was not envisaged many years ago. Rather, he would live out his life in that institution. Similarly the vision of some of health practitioners was that the original 10 that went to Rokeby would stay in Rokeby and probably die in Rokeby.

I am pleased to say that there has been some progression for some of those and even those still there from the original cohort have all made significant steps in their progression. That is from the psycho-social model rather than the medical model of recovery.

**Mr WILKINSON** - What is the reason for that?

**Mr CARLISLE** - I have a background as an administrator of a public hospital in Western Australia, and in mental health and listening to staff here. I think the difference is that when you visit a doctor you get 15 minutes. If you visit a psychiatrist you might get 45 minutes, whereas our staff can spend 45 minutes of every hour with a particular person, assisting them to give them hope and encouragement to map out their world and where they want to go. The clear difference is that we can give them hope; doctors can give them medication. This is where we re-empower them to make the choice of their life and where they are going and how they are going to do that work.

**Mr WILKINSON** - That was down at Rokeby. As a result of what you are doing you saw improvement which you believe would not have otherwise occurred?

**Mr CARLISLE** - I do not believe it would otherwise have occurred. These people have been in institutions; one of them has been in an institution for 30-odd years. Had they continued to be there for another 30-odd years I do not think the outcome would have been significantly different for that person. It is because the medical model is there to assist them to be medicated. There is not the focus on recovery, which is what Richmond Fellowship does. We certainly give them the hope, encouragement and support to make those steps. They are small steps and it can take time for even a simple thing like catching a bus. I draw on my experience from Western Australia. I was talking to a social worker on the way to work one morning and I said, 'What's your day?' and she said, 'I'm picking up a person from Subiaco, coming back to Fremantle, walking up and taking him back.' At the end of the day I saw her and she was very tired out, she had spent almost that whole day getting this person from their home to the train station, negotiating getting a ticket, getting to Fremantle, negotiating the 15-minute walk up to the hospital, making an outpatient clinic visit and going back, so that was very resource-hungry for that one individual. On that day Peace - and that was the person - would have spent a good five hours of her working day doing that. Clinicians do not generally have the luxury of that time whereas that is part of what the community sector does, supply that time and effort and focus on those issues. We work collaboratively with the mental health team to supply the medical side of their needs and we work in that.

**Mr MARTIN** - I agree strongly with the comments you make on page 2 about economic rationalism. The point you make is that no amount of best practice legislation can compensate for the lack of on-the-ground resources. How deficient do you think we are in this State in relation to resources for dealing with mental health?

**Mr CARLISLE** - I actually talk later into the document about the ongoing review under the Tasmania Together progress report which is on page 3 and their report showed the percentage rate for a person with a serious mental illness whose needs are met by the Tasmanian service has dropped from 44 per cent in 2006 to 40 per cent in 2007.

**Mr MARTIN** - And the really scary thing is that that has happened during good economic times, so what happens next?

**Mr CARLISLE** - That is right. I asked that question of a forum we were at recently and the answer I received was that that was also the state of flux when the Bridging the Gap processes started and they started to devolve the MIST teams and the other resources being relocated around the State. In respect of that, I do not believe 44 per cent is a good number to hit. If that is our bottom line, and it really is a bottom line, the resource implications there are quite dramatic. The issue of where to take it through from here is at both ends of the spectrum. We need to make sure the services provided at the hospital and at the community level are there, and sufficient to deal with the needs of those people within the system, but also we need to do the work at the other end of the system, which is the prevention and intervention work.

At a recent conference in India, they were talking about the intervention there of health practitioners. They said you can monitor somebody's diabetes daily by a health practitioner, so every day you would present for a 15-minute service and that health practitioner can deal with that person's diabetes, or you can spend two hours and train that person to deal with their own health condition, which is part of the focus that we have at Richmond Fellowship, as do some of our other community sector organisations, to train the people to understand their illness. Once they understand their illness they can start managing it. I think the question you asked earlier about that being no different from any other service is correct. If you are in hospital for diabetes or a mental illness, if you understand what the illness is and how it affects your life you can start taking some carriage of what treatment you take or do not take. The lack of knowledge is an impediment for a lot of people, whether it is a mental illness or diabetes or multiple sclerosis or whatever. Once you have a bit more knowledge you can take more ownership of the direction of the situation.

**CHAIR** - Do you think part of the stigma of mental health is that when someone is diagnosed with a mental illness people think they are also not very bright because mental illness relates to the brain and the capacity to reason and think relates to your brain? Is that an issue here?

**Mr CARLISLE** - A perception that some people do have is that people with mental illness are stupid. Again drawing from past experiences, that is not the correct way. I draw from experiences in Western Australia - a wheelchair-bound person who was stuck on the second floor of a secure unit at Graylands Hospital. There is a ha-ha wall, a low wall, and when you look from street level there is a trench on the other side which is usually about 3 metres or higher. This person was stuck on the second floor in a

wheelchair. The police picked him up out on the street halfway down the road in his wheelchair trying to head to the pub. He may have been ill but he was not stupid. He figured out how to get out of that hospital, how to get out of the second floor, get his wheelchair there and get down the road to the pub.

**Mr WILKINSON** - He must have been thirsty.

*Laughter.*

**Mr CARLISLE** - It was a big thirst. It is like all motivators in life.

**CHAIR** - Where there is a will there is a way.

**Mr CARLISLE** - Exactly. You look at what is happening in Victoria right now. A lot of people willed their way out of the conditions they have been in. Stuart Diver, who was trapped in the Thredbo landslide, actually willed himself to live on. The will is the driver here. The mental illness is just an illness like diabetes that impedes some of your life. It does not affect you. I use diabetes because it is one of those illnesses that is hidden as much as mental illness is. You cannot physically see most diabetics, so you would not know without their declaring that they are a diabetic or such like. If somebody has a broken arm you can see it and you can give them sympathy. If somebody has crutches you know that there is an illness or injury. But with a person with a mental illness, you cannot see that generally. Sometimes there may be those tics that people get - you have all seen those Tourette's ads on television - or it may be that they are walking down the street talking to themselves. I must admit sometimes I am guilty of that. I will walk through a discussion I am going to have. Probably people thought I was crazy when I walked into this building just thinking about what I was going to talk to this committee about.

**CHAIR** - You've come to the right place.

**Mr CARLISLE** - Indeed.

**CHAIR** - You are safe with friends.

**Mr CARLISLE** - Thank you.

**Mr MARTIN** - If you walk past my office you can sometimes hear me talking to myself, doing a speech.

**Mr CARLISLE** - You look at some of the great thinkers, the great artists of the times: there has always been a fine line between insanity and genius and that has been very much discussed. I was at a talk last night about Darwin and one of his major mentors was a manic-depressive but he was also a genius in his own field of expertise. So there are these people who have the knowledge and skills. We see the young person that goes to university and people say, 'It is because of the pressure of university'. Sometimes the illnesses do not manifest until they are in their late teens or early twenties. They will pick that time to affect somebody's life. Of course, yes, there is a bit of causal stress there that will add to that, as with all the other changes there, but there is no barrier to mental illness. It is not the mentally infirm. If that were the case all people with a brain

injury would have a mental illness, and that is not so. Or there may be an onset because their capacity to do other things may cause them stress and depression, so that they cannot be normal as everyone else is. No, there is no correlation between mental illness and mental capacity.

**CHAIR** - So that being the case - this is part of the argument that has been suggested - currently within our existing legislation a person with a mental illness who has capacity to make a decision can still be treated without their consent as opposed to a person who has capacity and has a physical illness can refuse treatment and his refusal is respected. Do you want to make some comment on that?

**Mr CARLISLE** - I was listening to that very point. The capacity to make a decision can be sometimes impeded by the mental illness. However, there are times that people can make a decision about their illness or about their regime of treatment. There was very poignant case law that was developed in the UK. I read about it in a handbook, which was a guideline to the Mental Health Act of Tasmania. In that guideline it talks about a gentleman of a Caribbean background who had a mental illness and was in hospital for his mental illness but also had a gangrenous leg. He argued with the tribunals and to the courts that he should not be forced to have his leg amputated because that would diminish him as a human being. The courts were able to rule the he had the right to make a decision not to have his leg amputated, which resulted in his subsequent death, but he had the capacity to make that decision at that time and it was judged that he had that capacity. I think the sole difference is the determination of a person's capacity to make that informed choice. It is sometimes assumed that because somebody is in hospital - and they may be an involuntary patient - they don't understand what has been happening. They might not want to take that medication because of the side effects it causes them. This is sometimes where the right to make that challenge to their treatment order is imperative - that they have the right to argue their case. That is where the tribunal's ability to make a judgment in this respect is important.

**CHAIR** - You would deal with the families of people you have in care?

**Mr CARLISLE** - Yes.

**Mr CARLISLE** - Some families claim that they can't get any information about their family member. They feel they should be able to get it, are entitled to get it and they need it. Others say that they will give information but it won't be received. What do you see as the most appropriate process here?

**Mr CARLISLE** - I think carers' involvement in treatment is imperative and where the participant wishes to have a family member connected with them we encourage it. Sometimes that is where the issue may be and it is very hard to give a blanket answer to that one. It is on a case-by-case basis that they need to be considered.

If you look at the situation where a young teenager suffers from a mental illness and lives at home, mum might see that small tic that shows that that young person is not taking his medication or is becoming sufficiently unwell. The mother should be able to inform the doctor about that issue. Some practitioners - and again I am drawing from my experience in WA - will listen to that mother about that issue. As the head of department said, there is no problem with listening to a carer about their interpretation of what the

situation is. It is how you then treat that information, accepting that it is true and factual or it is just additional information that will help them to make their determination about the treatment for that individual.

It does have a place in it but it also has to be balanced with the rights of the individual and this sometimes is the conundrum with informed consent and who should know about what treatment is being given, whether it is mental illness treatment, blood tests, angiograms or whatever. That is the question about how much accessibility a wife, friends or children should have to medical records. As far as I am concerned at the current stage, I don't care if they know what my medical conditions are but some people are very guarded about what conditions they have. That is probably historical or family construct, where they have been brought up not to discuss their own individual health. The stalwart father who gets up and goes to work with chest pains but won't talk about it because that is what blokes do. There is a fine balance between the right of the carer to be involved in the treatment of a patient and the right of the patient to keep the family uninformed. I believe it is very hard to legislate to say that you must listen to a carer. I think that has to be instilled at the point of contact. As I say in my submission, a schoolteacher is with a student for nearly eight hours a day; the child goes to school, comes home, goes to bed. In those eight hours a teacher may notice a subtle difference and that subtle difference might show a change in the mental state of that individual. We need to be balanced in how we do that.

You ask whether it should be legislated that carers should have rights. I do not think you can encapsulate the rights of the carer into the legislation, but they can be encapsulated into the notions behind the legislation. In the training processes that we undertake as we develop new clinicians is the understanding that these rights should be there. This is same as when an elderly person goes into hospital following a heart attack. The partner will usually talk with the nurse about how they should be treated when they get home et cetera, and that is the same sort of balance you could have.

**Mr WILKINSON** - Does that happen now?

**Mr CARLISLE** - In general health -

**Mr WILKINSON** - In general health it does with a step-down, but what about mental health?

**Mr CARLISLE** - Again, there is a perception about the privacy barrier that goes up in some places. It is down to the individual clinicians who work with clinicians in the same areas. A number of WA clinicians were very strong in that perception that involving the carer in the patient's treatment or working out their recovery plan was imperative.

**Mr WILKINSON** - I would have thought it would be pretty well a prerequisite for allowing that person into the community because you have a carer who ensures that a person takes proper medication, sees if the patient may be suffering a relapse and therefore is able to contact the requisite authorities. Alternatively, if there is a change of medication, often the change in medication causes people to have a relapse. I would have thought that type of information should be given to all carers as the reasonable thing to do and if they didn't do it, it would be negligent.



**Mr CARLISLE** - It would not be negligent because the current legislation and privacy laws say that I cannot disclose to you what has happened.

**Mr WILKINSON** - Don't you think it should happen?

**Mr CARLISLE** - I believe it is best practice in the fact that it helps that person to maintain the medication.

**Mr WILKINSON** - The paramount interest should be the interest of the patient in situations like this and I would have thought that the paramount interest of ensuring that the person is properly cared for overrides the interests of, let's say, privacy.

**CHAIR** - It is a fine line.

**Mr WILKINSON** - That would be my view.

**Mr CARLISLE** - There is a very fine line in defining privacy. A number of practitioners will do that with the consent of the patient. As we go to our GP, or are discharged from hospital after an illness, I would ask my wife to be present so that she can understand what medication I am given and when I have to take it, when to change the dressing and so on - all those things that I could forget because it is going to come at you at 100 miles an hour. Like all medical and mental health treatment, it is usually, 'You'll be here for a couple of days. We need the bed, out you go' and it is all packaged up and off you go.

Part of my working life was in surgery. We were granted some money to do a wait list for hip replacements. In part of that process some of the clinicians, the social workers and the nurses got together and made up a pamphlet about what would happen to you before you came in and when you were in hospital. It included such things as the fact that on day 1 you would be got out of bed, walked around, sat in a chair while the bed was made and put back into bed. It also included things such as whether you would feel a lot of pain and when you could expect it to subside, and whether you would be black and blue from the knee to the upper abdomen. These patients went in informed and were dictating to the nursing staff what should be done next. 'I haven't been up for my walk today, nurse', 'I don't need medication because I know there is a standard practice that I am going to have that medication'. That sort of information reduced our workload but really upset some of our nurses. They actually were being told what to do by the patients because they had been informed about their illness and what to expect.

**Mr WILKINSON** - Because that still happens, doesn't it? A mate of mine in Melbourne just had one done and I had a look at the document that he got. It tells them the type of operation, what to expect, day one, day two, and week three and four.

**Mr CARLISLE** - Yes, and how inappropriate to inform them of what is going to happen to them. Let them guess what is going to happen; keep it a secret, it is medical. For a person being discharged with a mental illness, the information that they should go out with is how their mental illness is going to affect them. There is a strong correlation between the drug clozapine and weight gain. These are issues that become standard. A number of people come of hospital, start taking these tablets, gain weight, understand the correlation and stop taking the tablets, which is probably the worst thing you can do because there is a very severe adverse effect of stopping overnight. It is like all

medication, it should be time-traded out. It is that critical point about informed people and that should be part of it. I believe there has to be that fine line between privacy and right. If somebody has been discharged to home then the family should be given the opportunity to find out, or the consumer of mental health should be given the right to ask that somebody else comes along and learns about this.

**CHAIR** - In an ideal world, discharge planning starts at admission.

**Mr CARLISLE** - It does and that is very much the same here. You have to start discharge planning from day one. In Fremantle Hospital where I worked we had a catchment area of 500 000 people, so it is about the same size as the population here and the same sort of issues. It was a port hospital; it also had inner-city, suburban and a rural/remote area as we stretched down the coast of Western Australia. So we had similar areas. One of the things that I think we did subtly differently is that our community team was also part of our in-patient team. So if they are in the community and they are recommending that somebody be admitted to hospital they knew that when they stood on the other side of the door they were going to be involved in that person's treatment in the hospital. This is for the community psychiatrists, psychologists and registrars, not the nurses. They were two different groups because of the subtle difference between their work practices. The important fact was that they would not send somebody to hospital because they had a whim that they might be better off or they did not know what to do with them in the community. Once they do that they are going to have to treat them in a hospital anyway. Similarly they would not discharge him into the community if they were not ready to go back to the community because they knew that they were going to pick it up on the other side.

In Tasmania the hospital is its own silo and the community teams are in the other silo. Although they have discharge planning and all those other lovely words, I do not think effective communication is there between the two. We have seen a number of our residents being taken to hospital because the acuteness of the illnesses is elevated and then at 3.00 a.m. we will get a phone call that such and such has been discharged and you have to pick them up. When we get there we find that it is usually because somebody with a greater illness has been bought in and they need that bed. They know that at least with our community organisation that they are going to get some coverage, treatment and services while they are there. This notion is not always carried forward, or they will be discharged with two days of medication on a Friday night of a long weekend so there is no way of getting the rest of the medication before they go back in.

**Mr WILKINSON** - Are there enough people to do that type of work that you are talking about within Tasmania at the moment?

**Mr CARLISLE** - In the community sector?

**Mr WILKINSON** - Yes.

**Mr CARLISLE** - No.

**Mr WILKINSON** - It would seem to me to be no. That being the case, what should happen?

**Mr CARLISLE** - Perhaps I should give you a bit of history of the Richmond Fellowship. When I arrived four years ago we had 17 staff, a head count of about 10 FTEs. We now

have a 70 head count and probably about 44 FTEs across the State, so we have blossomed in probably three years. At the same time, the other services also got increased funding and also went through that rapid change. As part of the process of Bridging the Gap we did a review of the needs of work force development, not only for the community sector but also for health employees. We spent several months on it at a frantic pace because the department wanted to get it into the budget preparation time by October/November in that period. That has now sat somewhere within the system during that period. We raise it again every so often and receive, 'Don't worry about that now because we have a new review going on. We've just reviewed the strategic plan of the mental health services and that is part of it. We've set up the new office for the community sector and part of their brief will be to review how we do community service training across the whole spectrum - not only mental health'.

TasCOSS has just finished an industry plan submission that we have developed in consultation with all the community sectors in an attempt to again put it back on the agenda for government. They call us the 'third sector'. Sometimes we believe we are the first sector because the community sector started working and helping through institutions like churches, lodges et cetera that have been around for years helping each other and helping people develop their own skills. There has been a lot of work in that respect.

We, as an organisation, have ensured that we have picked staff because of their capacity to do the job and then we train them about mental health afterwards because the thrust of our work is working one to one with people and helping them develop their own skills. We have a couple of experts in each program who were the focus point of that program so they were able to assist the individuals in that way and by osmosis the rest of the staff have learned it. This year we had over 20 of our staff in a TAFE course, Certificate IV in non-clinical mental health, so we are putting it back there to educate our staff about mental illness and how they can help these people on the road to recovery.

We promote the word 'hope'. It is the catalyst. The moment they lose the hope of doing anything they are going to stop. That is where we can assist them to learn that, to help them set some goals and make those challenges. We do not get it right every time. We have a number of people in our programs who will stay for three weeks, three months, 12 months and then move on without perhaps achieving all the skills they need to live independently. They will then come back at some stage and rejoin and make it to the next plateau. We cannot go upwards all the time. We all need respite, time to stop and think about where we are going and what we have done and where we are going forward. It is imperative that we do not have a time frame on it and we are trying to keep that process going.

We have occasionally had some very successful opportunities. A gentleman from our outreach service in the north-west had been without a driving licence for 15 years. He lived in rented accommodation, sharing a house, and being in our program has given him some hope. He has a better understanding of his mental illness and has got on top of it and has gone back and got his driver's licence. Through the camaraderie he had developed with others they got his car certified as roadworthy after 10 years being up on blocks. He now works out of town and has a part-time job which has given him that hope that he has looked for. He has met a young lady, which expresses the wishes that everyone comes in with - a job, education, my own home and a partner. We cannot give it all to them. We will help them map out the steps they need to get to that point.

**Mr DEAN** - I think your point is very good.. Even if we have got the admissions right, even if we have got the treatments right, we haven't got the discharge process right. A good analogy here is Ashley where they bring them in, give them some rehabilitation and then simply discard them, throw them back in the same position and don't worry about them and then they are back again.

**Mr CARLISLE** - It is the revolving-door syndrome and that happens with mental health. The clinicians work on getting the person stable and once they are stable they are back out there. This is the constant problem we face with that process. The medical model tries to stabilise a person's illness and then puts them back into the community, whereas we are hoping that the community sector can assist those people to either maintain their level of health or do some more recovery to increase their lives and standards.

**Mr WILKINSON** - It does fit into the terms of reference because you have that catch-all at the bottom 'any other matters incidental thereto'.

**Mr CARLISLE** - I think that informed choice is a critical part of the legislation.

**Mr WILKINSON** - How have you found Tasmania as opposed to Western Australian? You have dealt in the field in Western Australia and you have been dealing with it in Tasmania. Is Tasmania better off or do you believe that Western Australia is better off? If so, why?

**Mr CARLISLE** - In regard to mental health, I believe Tasmania is slightly behind in that respect. Fremantle Hospital became a conglomerate where they chucked in their community team, an old institution and a few other pieces into one hit and said, 'Go for it, guys'. We disaggregated all that and built a team that covered inpatient and out in the community. The continuum of care, which is a word that you will hear in mental health, was there because the clinician who treated the person in the hospital was the person who treated them in the community. One part of the loop that I see as slightly missing here in Tasmania is that that continuum of care is not there.

**Mr WILKINSON** - Is that still happening in the Fremantle Hospital?

**Mr CARLISLE** - Yes. I have occasional contact with that. I was lucky enough to be in a Richmond Fellowship Asia Pacific Conference in India and I came across a couple of psychiatrists who are in Fremantle and they were talking about that very instance.

**Mr WILKINSON** - Who does it best in the States or Territories?

**Mr CARLISLE** - I have never done a comparison between the States. I think each one of us has our own uniqueness. The best I can suggest is that the 'less-restricted practices' - another catchword you will hear - is imperative.. There is nothing wrong with discharging somebody from hospital earlier than perhaps would be perceived as a good practice if there is somewhere for them to go.

With the opening of Rocherlea, which is the new step-down facility in Launceston, that should, fingers crossed, open up a stepping stone for people who are in the ward, well enough to be not necessarily in the ward but not well enough to live in the community. We had a similar service in Western Australia where you could step down from the

hospital, go into the community environment and spend up to 28 days there. From that, they were then able to return to a normal lifestyle.

**Mr WILKINSON** - Is there any place like that in Hobart?

**Mr CARLISLE** - Supposedly Mistral Place.

**Mr WILKINSON** - When you say 'supposedly', is that because it is not working as it should?

**Mr CARLISLE** - When you see the statistics where somebody has been in Mistral Place for 700 days, I don't think it is working well. The length of stay in those places is very high. Whether 28 days is going to be the point or it is somewhere in between, our service had an optimal goal of 28 days. We had people staying in our step-down facility for three months but the cost of that associated service compared to the cost of in-patient was much reduced because in a ward situation you need perhaps three nurses at night time. In the community sitting you may only require one or two staff there and they do not necessarily have to be a nurse. So economics comes into that discussion. We have no allied health people working for us. We have a number of social workers that work as community service officers but we do not employ them as social workers or occupational therapists et cetera.

**Mr WILKINSON** - In a number of places within Tasmania, as you know, there are carers. A significant number of children go back to care for their parents. They get a carer's pension. They are obviously up-skilled to some degree to enable them to care for their aged parent or aged friend or whoever it might be. Would you be able to do that with a partner or a family member, do you think, if you up-skilled those people to do the type of work that the Richmond Fellowship does - but maybe not to the same extent?

**Mr CARLISLE** - This is where we try to both empower the individuals and engage their carers in that service. We do not work in isolation with that particular resident or our outreach client. We try to encourage a connection with the family or the local community to assist those people. By reconnecting it makes it easier. Sometimes the isolation is the biggest challenge for our consumers. By assisting them there - again, going back to the medical model - if you understand when the tabs have to be done, what regime has to be taken to know the triggers which will cause that, you make that person better informed to assist them. And if somebody else is there at the same time knowing it, it makes it easier.

**CHAIR** - Thanks very much for that, Patrick. We have run out of time but it was very helpful. Thank you.

**Mr CARLISLE** - Thank you. If I can leave you with one thought it is early intervention. Again, whether it is the obesity trauma or it is mental health, early intervention would save a lot of problems in that area. I will leave you with John.

**CHAIR** - Thank you very much.

**THE WITNESS WITHDREW.**

**Dr JOHN ADRIAN CRAWSHAW**, DEPARTMENT OF HEALTH AND HUMAN SERVICES WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

**CHAIR** (Ms Forrest) - Welcome, John. You are obviously well across the terms of reference. We have read your submission so we would appreciate an overview from you as to where the department sits on this whole issue. We are very cognisant of the fact that we are hopefully at the tail end of the Mental Health Act review.

**Dr CRAWSHAW** - I can tell you where we are at with that.

**CHAIR** - I was hoping that you would. There will be questions and points of clarification that members will probably seek along the way.

**Dr CRAWSHAW** - As you probably appreciate, the submission was on behalf of whole of government through DPAC. As such, it represents an amalgam of views because it affects not just Health and Human Services but also Justice and various agencies. What we have tried to set out in the submission is a reasonably factual summary of where things are at and where some of the thinking was in terms of the new Mental Health Act. We have indicated in the submission that the terms of reference probably extend across at least four major pieces of legislation - the Mental Health Act, as it currently stands; the Alcohol and Dependency Act, which is the oldest piece of legislation, 1968; Disability Services Act, which again was introduced as part of the institutionalisation process for the intellectually disabled; and the Guardianship and Administration Act. I wasn't in the State at the time but, as I understand it, the Mental Health Act and the Guardianship and Administration Act were developed at roughly the same time, dealing with similar sorts of issues. The people who have been here longer may well remember and be able to tell me.

**Mr WILKINSON** - Should there be just the one act encompassing all of the above that you've mentioned?

**Dr CRAWSHAW** - That is very interesting. When we were going through the review process - and we have had various debates as to whether it should or should not be one - it was interesting that most other jurisdictions have ended up with two acts. Even in Britain, where it was very much a live issue in terms of the competency, they ended up with a mental health act as being quite distinct as well. From my point of view, I think that is probably more related to the fact that the Mental Health Act is not simply about substitutory decision-making for people who lack competence. There is something that one of my colleagues has called the *parens patriae* type component, where you stand in the place of someone to make decisions, and also the fact that there are issues with police powers - in other words, the need to protect the public. Within most modern mental health legislation you have a balancing of those facts. One is potentially around the assessment of risk and if you have the right sort of legislation it is not just the immediate risk but also the potential of risk and looking at early intervention. Our legislation at present, which is what we are trying to address, doesn't allow the earlier intervention that a number of people have made representations to us that they would like see.

**Mr WILKINSON** - Do you believe that early intervention is the appropriate way to do it? I know the evidence we have had so far seems to stress early intervention is the way to go.

**Dr CRAWSHAW** - The national plans and policy statements that have been developed in Australia over the last 15-plus years have stressed early intervention and certainly that is the way the most modern literature would stress. If you wait until someone is in extremis - if I can put it like that - it is much more difficult to bring the person back. There is also some literature that would suggest that each time someone goes through that cycle, particularly for the severe psychotic disorders, they lose some function in the process. The best opportunities you have are intervening early and in the first episode in a comprehensive way.

**Mr WILKINSON** - Is it a bit similar to, let's say, cancer? Often early intervention with cancer is a complete cure. Is it the same with mental health?

**Dr CRAWSHAW** - I would love to say that it would cure, but I think with my clinical experience I could not go that far. Just for the committee's knowledge, in the late 1980s when early intervention was first starting to be thought of, I was running a psychotic illness management team and applying some of these early principles. While I could make considerable inroads in improvement in the patient's condition, cure was not something I would term it. What I was trying to do was to preserve function, preserve the capability to return to good function. People forget that with good interventions even people with severe psychotic episodes can recover to remarkable extents. I can give examples of people with professional careers who were able to return to those professional and often quite stressful careers, who had very severe psychotic episodes which required compulsory intervention, what they termed at the time forcible medication, but we were able to restore them to not only good functioning but functioning that allowed them to continue to pursue their careers.

**Ms FORREST** - It is like long-term remission you are focusing on, in a cancer sense, rather than cure.

**Dr CRAWSHAW** - That is right. There are two parts to teaching modern early intervention. There is the part of intervening early so that the person doesn't get quite as severe, but also teaching the person with the illness, and their families and support members, how to intervene earlier in the stage when they start to go down next time, and strategies that they can use to prevent a repeat episode.

**Mr WILKINSON** - That to me seems important. Do you have enough resources to do that?

**Dr CRAWSHAW** - As people would realise, mental health in Tasmania went through the Bridging the Gap episode in terms of getting additional resources. We are still part way through a strategic plan and people would be aware that I commissioned, shortly after I took over the board of Mental Health Services, a stocktaking exercise just to see where we were with respect to that and we have an implementation plan which we are now rolling out. I found that a lot of people were involved in that process and we have some clear ideas of what we are doing well and what we could do better. I have to say that having been through this exercise in another life - it took me something like three to five years to transform services in that life.

**Ms FORREST** - Can I put Jim's question to you, because I do not think it has really been answered? You say in your submission, John, that 'the submission provides comments on the way forward including consideration of the benefit of generic capacity legislation' and Jim asked you whether we need one.

**Dr CRAWSHAW** - Coming back to that, I think there is a place for generic capacity legislation and from my perspective that generic capacity legislation does need to span a lot of circumstances, some of it with people who have enduring levels of incapacity, some with fluctuating conditions - something like a brain tumour, which causes a loss of capacity or because they are nearly moribund. You have to have legislation that covers 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.

I also think that, particularly with some of the international covenants - covenants around the care of disabled persons - you have to think very carefully about how you use legislation to protect the rights of individuals. My view, and this was reflected in the way we drafted the secure mental health components, is that you build in checks and balances to the system so that you have good protection of rights, good oversight, particularly for the mentally ill, when you are thinking about making decisions, sometimes in the interests of the community as much of the interests of the individuals. You have to have those checks and balances, you have to have the independent decision-making tribunal so that there can be proper oversight of it.

**Mr WILKINSON** - It is a difficult task though, because I think the real argument is 'Where is the line?' You have a privacy argument and also the paramount interest of the patient argument. My view would be that the paramount interest of the patient should be No. 1 and privacy should be under that.

**Dr CRAWSHAW** - I would have thought that first and foremost we are there for the patient but the question that will arise, and I can tell you clinically it arises when I am looking after patients, when the patient says, 'This is what I want' and you might say that is not in their best interests. However, six months later when I have treated them, they say, 'Thank goodness you didn't go along with what I said'. You have to have an independent check on that process and I am quite clear that you need checks and balances on the system. One of the parts that we are building within the draft legislation we are going through at the moment is the office of the chief psychiatrist so that we have a formal capacity to set clinical standards and to monitor what is happening. It is modelled on the powers which I have as the Chief Forensic Psychiatrist over forensic patients so that I can intervene and instruct in terms of protection if need be.

**Mr WILKINSON** - When I said 'paramount interest of the patient', to me, that would be the doctor prescribing as opposed to, first, the patient saying what he or she should get and, second, it would be the doctor being able to advise others of the problem, those others being carers or partners or whatever.



**Dr CRAWSHAW** - I would agree with you to a point because I know some of my colleagues are sometimes far too paternalistic. I am not saying this is the case just in Tasmania, this is a more generalist statement. Some need to learn that you can manage people by dialogue without having to resort to coercion.

**Mr MARTIN** - As a professional, can you see any way that you can take the subjectivity out of the decision making?

**Mr CARLISLE** - In terms of decisions around risk and so forth?

**Mr MARTIN** - Yes.

**Dr CRAWSHAW** - I would say that the most recent literature around risk assessment and risk management is moving towards what is called a 'structured clinical judgment framework'. Initially we had individual clinicians interviewing patients and making decisions on a *Gestalt* [an organised pattern or configuration of experiences]. Later, particularly in the risk to others arena, people started to find they could get better predictions as to whether someone would be a risk by applying some actuarial tables. One big study in America, the McCarthy study, found some perverse outcomes from this method because actuarial studies do not necessarily take into account some of the individual characters.

**Mr MARTIN** - They are anomalous. They are not very good with humanity.

**Dr CRAWSHAW** - The latest studies by people trying to work out how best to make these decisions is what we call 'structured clinical judgment' so that you use frameworks which apply the best of the literature to guide the clinician in the interviewing process and the assessment and weighing up of risk. Some of those have very good predictive powers, particularly in terms of my area, forensic psychiatry. I think we have moved a long way from a purely subjective guess and professional opinion to much more of a scientific approach, if I can put it like that, in terms of clinical judgment.

**Mr MARTIN** - Would there not be an element of it depending on who the doctor is?

**Dr CRAWSHAW** - Yes, the quality of the training and the amount of experience will make a difference, but within our Mental Health Services we are using a tool which is a structured assessment of risk in which we train our staff. That helps informed decisions around risk. It does not prevent either the false negative, which means that we say the person is not at risk and yet they are either to themselves or to others, or the false positive where we say, 'This person is risky' but they are not. When you do analyses in the literature and think about it you look at what is the false positive versus the false negative rate. I will not get into the science of it but it is about how you judge the performance of these tools. The interesting thing is that those people have thought about how they apply it, much like the same application of measurement of risk and so forth within the airline industry and others, trying to eliminate the concern that you have which is that it is too subjective. We have moved a long way in the elements that we look for in terms of risk assessment.

**Mr MARTIN** - Where do you draw the line? Going back to what Jim raised about the rights of the individual to have some say in the matter, whether he is right or wrong.

**Dr CRAWSHAW** - I think that good clinical practice would dictate that we always try to take into account the wishes of a patient. Sometimes you cannot because they are not able to communicate with you and therefore you will intervene in a more assertive fashion. But as soon as the person is in a state where you can have a dialogue with them you should start to talk with them about what options they may consider. They may say no to one form of medication but agree to a different form of medication and there may be a slightly different side effect profile and so forth but that may nevertheless be acceptable. Just on that you might say we will give you a go on oral medication since you do not like needles but if you become non-compliant and as a result of that non-compliance you suffer a relapse of your condition and become of concern we will have to go to the use of injections. It is that sort of good dialogue which is part of good modelling psychiatric practice.

**Mr MARTIN** - Nearly every witness today has agreed on one thing. That is that ideally all three acts should have been reviewed at the same time. Some have then gone on to say that we should defer making any decisions on your current review until a total review is done of the three.

**Dr CRAWSHAW** - I would have considerable concerns about leaving the current legislation as it is because I do not think it provides sufficient protections. I think that there is not sufficient monitoring of some of the activities and it does not give me, or rather my new Statewide Clinical Director who is probably going to be the Chief Psychiatrist, the capacity to intervene and instruct around clinical practice for the patients' benefits. I think that the legislation as it was written in 1996 was reasonable quality legislation for the time. I think the debate in terms of rights of patients with mental illness or individuals who fall within our system has moved on and there is a much greater expectation that their rights will be protected. If you talk to consumer groups they would say that they would like to have their rights protected and for there to be a much greater oversight when they are placed in some sort of compulsory care. There are some fundamental issues at the moment in that you can have someone detained but with no right to treatment. Professionally I find that extremely problematic - that we are prepared to intervene and detain someone but not prepared to necessarily guarantee them the right to treatment that will restore their independence.

**Mr MARTIN** - You do not think there is the same need or pressure on to review the Guardianship and Administration Act?

**Dr CRAWSHAW** - The dilemma I have is that we were mandated to conduct the Mental Health Review. Actually, we should have been starting the review some time ago but the legislation said there should have been a review, I think, within a year. We certainly were aware of a lot of problems with the performance of the Mental Health Act and then, hence, why we believed that we should press ahead with a review of the Mental Health Act. In terms of the guardianship legislation, that is actually much wider than the narrow focus within mental health. You could argue that the guardianship legislation should also be reviewed.

**Mr MARTIN** - Any plans for that?

**Dr CRAWSHAW** - I would have to defer that and get advice from Justice about that.

**CHAIR** - Justice made some sort of positive noises at Estimates last year when questioned.

**Dr CRAWSHAW** - I think that if we went down the route of reviewing the guardianship legislation there would have to be extremely wide consultation because it impacts on a whole lot of things other than just the treatment of the mentally ill. My view is that there is a pressing urgency to address some of the rights-based aspects within the current legislation on the treatment aspects of the current legislation. Undoubtedly there will in time be a review of the Guardianship and Administration Act and that will then pick up some of the mental health legislation. It is an interesting thing: if I stand back and look at jurisdictions world-wide the mental health act legislations are always under review, always under change.

**Mr MARTIN** - I suppose the other criticism that has been made today by a number of witnesses is the perceived lack of consultation in this current review.

**Dr CRAWSHAW** - I am not sure that I would say that there has been a perceived lack of consultation, no. There has been quite extensive consultation. Two papers were put out. A lot of people made submissions. There were forums held right around the State. Currently we are trying to finalise the bill in a form that can then go out for further consultation.

**CHAIR** - What is the time frame for that?

**Dr CRAWSHAW** - I have the time frame here somewhere, but I cannot think of it off the top of my head. It is a complex piece of legislation so it is taking us longer to draft and get it in a form that we can release for public consultation. We were hoping to get it into a form where, come March, April, we can consult with it over a six-week time frame for public consultations and then come back and pull it together a bit so it can get into Parliament by the September sittings.

**CHAIR** - It will not be this sitting of Parliament then as suggested by the minister previously?

**Dr CRAWSHAW** - No, it will not be.

**Mr WILKINSON** - Mind you, the lack of consultation argument has been put about a lot of legislation. You hear that cry about a lot of pieces of legislation, don't you?

**Mr MARTIN** - I think part of the reason there is that concern is that there is a belief that the legislation was already before Parliament.

**Mr WILKINSON** - I think you are right.

**Mr MARTIN** - I think that will put some people's minds at rest.

**Dr CRAWSHAW** - Maybe I should also say that it is our intention to go to an external consultant to review the legislation. We are in the process of contracting independent experts in the form of an external consultancy firm. Although it is not quite finalised in terms of contractual arrangements, it includes Professor Bernadette McSherry - who

some people may know as probably one of Australia's foremost mental health legal experts - Penny Wheeler and Gillian Gardner from Victoria. We want to ensure that we close off on all of the issues we are concerned with and achieve the right balance.

**CHAIR** - So you will send them the draft legislation?

**Dr CRAWSHAW** - Yes.

**CHAIR** - As well as sending the same draft legislation out to these key stakeholders?

**Dr CRAWSHAW** - Yes.

**CHAIR** - So they will all get it at the same time?

**Dr CRAWSHAW** - We are in the process of trying to sequence it so that we can get things done properly. If we have the time, we may send the experts an early draft to finalise it so that it can then go out. Otherwise, we may end up sending it to all three. We have an advisory group, we have the public consultations which we are planning over the six weeks, and we also have the external validation process. We are committed to trying to get this the best we can within the time frames that we have.

**Mr DEAN** - In the modelling of the draft of the legislation, what areas are you going to get support from outside Australia, for instance? What other countries in the world, do you think, have got this right and that you are going to have a look at?

**Dr CRAWSHAW** - John Lesser did a Churchill study. We are very fortunate he did a study of all the legislation in a number of jurisdictions. We were able to receive copies of that last year some time. It is quite a varied placement as to what various countries do. He seemed to find greatest favour with the Scottish system. The Scottish system is in fact probably the closest to what our thinking is in terms of how we are writing the legislation.

**CHAIR** - They still have a mental health act?

**Dr CRAWSHAW** - Yes, they do.

**CHAIR** - Do they have a capacity-based model?

**Dr CRAWSHAW** - They have a capacity component as well as a risk component in their legislation and they talked about the balancing of that.

**CHAIR** - Are you able to provide a copy of John Lesser's paper?

**Dr CRAWSHAW** - It is not a published paper, so we can check with him whether he would be happy for us to release it.

**CHAIR** - That would be appreciated.

**Mr DEAN** - Would any other State in Australia have it?

**Dr CRAWSHAW** - Victoria is about to start its big review of its mental health legislation. I think one other State is also about to commence.

**CHAIR** - ACT recently reviewed theirs, didn't they?

**Dr CRAWSHAW** - Yes.

**CHAIR** - What is your view on the ACT legislation?

**Dr CRAWSHAW** - We have tried to keep faithful to our consultation process. There are parts of other legislation which we see would be of benefit and some we wouldn't necessarily want to follow through with, and certainly would be contrary to the advice that we received in terms of the public consultation. So we are trying to pick the eyes out of the best parts of it.

The ACT have recently reviewed it, but they also had some provisions, and I am not prepared to put them in public, parts of which I was concerned about.

**Mr DEAN** - You are putting together a draft for the legislation and you say a number of States are looking at it and considering it. We understand that an order made here cannot be transferred to another State and doesn't hold any bearing in another State.

**Dr CRAWSHAW** - One of the pieces of work that was done was to ensure that all the legislation has capacity for orders to be transferred. 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. We had a debate at the Mental Health Standing Committee on Friday about precisely this point.

The real issue is not so much the civil components but the forensic components of the various mental health legislations because they are critically dependent upon the criminal codes or civil codes but also the various constructions of the criminal justice system. For instance, we are a code State; other States aren't code States and that creates issues.

**CHAIR** - John, I take you back to focus on the terms of reference. On page 5 of your submission -

**Dr CRAWSHAW** - About the role and function?

**CHAIR** - Yes. You make the comment that for people who are unable to provide consent for treatment of their condition, legislation provides a structure, a substituted decision-making framework. Further down it says that the compulsion is justified on the basis of risk of harm to the person and to others. We have had discussions with a number of witnesses and many submissions around this issue of potential harm. A very hypertensive person who is refusing to take anti-hypertensives poses a significant risk of harm on the road if driving in that state, for example. It is only in this setting that people can have the capacity to say, 'I have the capacity to say I don't want to take my anti-hypertensives, I don't like the side effects of them', or whatever. A person with a mental illness can say, 'I understand the side effects, I know that I'm not a particularly nice

person', or whatever, 'when I don't take my medication, but I'm not going to'. Does this discriminate?

**Dr CRAWSHAW** - Certainly that is part of why I am quite keen to see the checks and balances of the mental health legislation because I think you only intervene to that extent if you have very clear, justifiable reasons that are related to public safety, or the safety of the individual, and their judgment capacity has been impaired.

I think it is extremely problematic because we know that a small proportion of people with severe mental illness, and often severe mental illness and a combination of alcohol, drug and personality problems, in the more recent studies have been demonstrated to show a higher risk than the average member of the public. The public has, rightly or wrongly, decided that they need to be protected from them. Part of the balancing act in writing any mental health legislation is saying, 'Yes, there is an expectation of protection from people who are not making appropriate decisions and posing risks to others', there is also a need to protect the individual whom you then impose that on, to have their rights preserved so that they have the least restrictive care offered and for only as long as is necessary for that. That is some of the uniqueness of mental health legislation versus general incapacity legislation, if I can put it like that. I take your point that we don't tend to do that with people who have significant medical conditions. However, in the issue of road transport, if I as a doctor am aware that someone has a medical condition that impedes their capacity to drive I have, in most States, an obligation to report them to the licensing authority and there is a consequence they may well lose their licence.

**Mr WILKINSON** - That happens here, too, John, as you know.

**CHAIR** - People with epilepsy are certainly in that category. Even when they are medicated they are still in that category.

**Dr CRAWSHAW** - Yes, that's right. You could argue that they are more discriminated against. Society will say, 'If someone is going to behave in a way that is placing me at risk, please take them off the road', or they lose their licence or the capacity to do so.

**Mr WILKINSON** - The onset of the use of drugs over the last 30 years has been marked. Years ago - and this is more forensic and criminal than anything else - people got into trouble as a result of an overuse of alcohol. Now it would seem it is because of the overuse of drugs that they are finding themselves in trouble. As I understand it, approximately 80-90 per cent of people in Risdon at the moment have some type of problem either with drugs or alcohol. Approximately two years ago there was only one person over there who could assist in relation to their problems. What difference have you seen in your experience over the last 20-30 years because of the onset of these types of drugs - ice, speed, ecstasy, marijuana et cetera?

**Dr CRAWSHAW** - Firstly, in terms of ice, speed and the very bad problems, fortunately so far Tasmania has been preserved from the worst of what is seen in Sydney and Melbourne.

**Mr MARTIN** - It is still pretty bad, though.

**Dr CRAWSHAW** - I am not saying the individual cases aren't bad, but we don't see the higher proportion that they do. 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-medication 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 decision-making.

**Mr WILKINSON** - Am I right in saying that if a person has a propensity within their body for a psychotic episode then that propensity can often be sparked by the ingestion of drugs?

**Dr CRAWSHAW** - It can certainly be aggravated for some particular drugs, the one we used to worry about was PCP, or angel dust.

**Mr WILKINSON** - LSD.

**Dr CRAWSHAW** - 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.

**Mr WILKINSON** - Therefore can we take the next step and say that, as far as criminal activity is concerned, they are often the underlying explanation as to why a person commits a crime? Early intervention would be of assistance. How do we cope with that early intervention in relation to that? Is it more advertising campaigns, education or all of the above?

**Dr CRAWSHAW** - You are taking me into another part of my roles. I think that there is a concerted need to deal with alcohol, for instance. The committee may be interested to know that we are in the process of developing a Tasmanian alcohol action plan to try to address it in a multi-factorial way. When we come to recreational drugs or drugs that people choose to absorb, it is really quite a multi-factorial thing that we have to do in terms of intervention. Yes, advertising. Yes, health promotion or promotional activities. Some of it is about the cost of the product because we know that with alcohol that can create a barrier to people escalating their consumption, and certainly it has been one of the tools used for tobacco. So there is a whole host of measures which need to be used, from early intervention strategies right the way through to assisting people who have got themselves into trouble and helping them understand that they need to change. Of course that is why we have the future directions for alcohol.

**Mr WILKINSON** - If the problem could be tackled aggressively, do you believe your work would be as busy as it is now?

**Dr CRAWSHAW** - I would like to believe it would not be as busy but we do know that for at least some of our major psychotic and mood disorder issues there are genetic loadings. We do know that some of these illnesses tend to run in families and that for some of them

the stresses of modern society can lead to difficulties. The combination of factors is really what we end up looking at. Obviously taking alcohol and drugs out of the equation would assist us but would it actually reduce the prevalence of some of the major mood disorders and the high prevalence disorders? That is uncertain. The high prevalence disorder studies recently released show that a number of the people who actually have a high prevalence disorder do not recognise they have it yet it is severely incapacitating their lives.

**Mr MARTIN** - I raise the issue of voluntary admission. I dealt with a father who was absolutely at the end of the road, very emotional, dealing with his son for 30-odd years. The problem is that both the RHH Department of Emergency Medicine and also the mental health support crisis line have basically turned his son away because he is not diagnosed with one of the five major categories, yet there is no doubt that he has a serious mental illness.

**Dr CRAWSHAW** - I suspect this is one I became involved with this week.

**Mr MARTIN** - I notice on page 19 you talk of refining the process for voluntary admission, but it just seems from this case that people are falling through a gap.

**Dr CRAWSHAW** - No legislation is going to solve the surface delivery issues that you raised. That has been part of why I have been in the process of introducing a very strong clinical governance focus within the Mental Health Services, to try to address precisely the issue that you are raising, which is people falling through the gaps.

**Mr MARTIN** - Can I just say, though, that clinicians seem to be using the current act as an excuse.

**Dr CRAWSHAW** - I am well aware of that, which is part of why in our drafting process we are looking at the capacity for the Chief Psychiatrist to provide clinical guidelines to guide people in their decision-making around those sorts of application issues and, if need be, standing orders to try to address some of those.

**CHAIR** - But is this not going to require significantly more resourcing in the hospitals and in the services that are provided, because the reason these people are being turned away is that there are no beds?

**Mr MARTIN** - It really is a matter of resources and the restricted definition of mental illness.

**Dr CRAWSHAW** - I am fully aware of the issue. I know that I was quoted in a New Zealand commission of inquiry saying something similar. Resources are only part of the issue; it is also about how we get some of the clinical processes working in a more efficient and effective fashion, also looking at how many hand-off points we have in the chain in terms of clinical care. Some of it is about resourcing in terms of case management and maybe supported accommodation, but it may be that we are not using some of the resources at the earlier stage which would prevent the burden falling at the latter stage.



I am not saying that more resources would not be useful but we have to be careful that we do not automatically assume it is simply a resource argument and not look carefully at whether there may be some improvements in clinical practice.

**Mr MARTIN** - I think we both know the circumstances of the case.

**Dr CRAWSHAW** - We are assuming that we are talking about the same one.

**Mr MARTIN** - Yes, I think we are. In a case like this you are saying that persons should not be falling through the gaps?

**Dr CRAWSHAW** - I am saying that for cases where we have people falling through the gap part of what I am trying to introduce is a process where we analyse why they are falling through the gap and so try to put in place systems to prevent it. While legislation in the form of us being able to write guidelines and standing orders to actually address the interpretation of the act will help, some of that is also the major piece of work which I am doing at the moment in terms of improving clinical standards.

**CHAIR** - Just on that point, on page 14 of your submission you note that the number of times the provisions of the Guardianship and Administration Act are used to consent to medical treatment of patients would be far greater as the act provides emergency treatment without consent and for consent by a third party or the responsible person. You are saying that the occurrence of these uses is not quantified at this time and further on you say that a capacity test is not used for detention under the Mental Health Act. It is possible that some patients being held in detention due to the risk of significant harm might have the capacity to consent to treatment and in fact do so but again that data is not collected. How can we really know what is going out there and what the challenges really are if this sort of data is not collected? We end up with situations where people do fall through gaps and we do not really know how many people are actually willing to consent or would refuse to if they had the capacity to do so.

**Dr CRAWSHAW** - Some of it is to do with whether we actually capture some of the points. One of the things that we are concerned about, for instance, is that the current initial orders are not reviewable and not necessarily sent in anywhere to be reviewed. We believe that that should be addressed in the new legislation.

**CHAIR** - Within 10 days, was it not, within the discussion paper?

**Dr CRAWSHAW** - We are looking at having all orders notifiable and reviewable so that we actually capture some at the start. The second part about it is that currently we have a largely manual-based system, which makes it problematic in terms of getting data. We are in the process of trying to address that. You may remember there was money in last year's Budget for us to try to redress the clinical information systems within mental health. We are trying to proceed along that path and have made significant gains in terms of our ability to capture patient outcome-related data. At the moment, however, because the tests are applied in different places we do not have the capacity to say, 'We want to capture all of this data'. That is problematic for me. One thing we are looking, which is probably why it is taking us a bit longer to draft the act, is working out which data needs to be captured at which point so that we can provide a proper monitoring function. The current act does not allow that.

**CHAIR** - Will the proposed changes address those issues and the accuracy of data collection?

**Dr CRAWSHAW** - Yes, because people will be required to provide us with that data.

**CHAIR** - Again, it comes back to resourcing, doesn't it? One of the fears that has been raised is that the proposed amendments to the Mental Health Act are broadly supported although there are some areas of concern and because there is no draft to look at people are reluctant to make a comment which is quite reasonable. A comment is that a lot of these changes are resource-intensive even if they are very necessary. One example is the proposal for a chief psychiatrist, and even the initial review of all these orders will again be a resource matter. There is a fear that any legislation tabled, because of the resourcing issue and the current economic climate, may be passed but sit there for three years, as the Mental Health Act did originally, and not be proclaimed, and by the time three years have passed we would be behind the eight ball in terms of world's best practice. Do you want to make a comment on that? Do you have a similar fear?

**Dr CRAWSHAW** - I have an instruction from my minister to get the bill into Parliament as quickly as possible. We know that there are resource implications.

**CHAIR** - I appreciate that you cannot go any further than that, but do you acknowledge that there are significant resource implications?

**Dr CRAWSHAW** - There are resource implications, particularly in terms of the functioning of the tribunal as proposed.

**Mr DEAN** - In relation to young people, there is a perception that there are no facilities in this State for the treatment of young people with mental illnesses or mental problems. In the main they are treated with adults in adult facilities and that that does not really do any good for many aspects of their recovery. Is your review addressing that? Is it an issue? Is it a problem?

**Dr CRAWSHAW** - 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.

**Mr DEAN** - I do. It came up with the Ashley inquiry, that the small population meant they could not assist the youth in the same way and they can in other places.

**Dr CRAWSHAW** - 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.

**Mr DEAN** - The other issue that has been referred to today is the ongoing support and assistance provided to these people once they are released from the system. There are many examples where they were released into hotel or backpacker accommodation and it is only a very short time before we see those people coming back into the mental health system.

**Dr CRAWSHAW** - That is the issue of a stable accommodation. That effect is probably more broad than just the application of the Mental Health Act per se. All I can say is that I am in discussions with Housing over how we address some of those issues.

**Mr WILKINSON** - I hear what you say in relation to the act itself; your instruction is to get it before Parliament as swiftly as possible. In doing that you realise there may be a resource problem.

**Dr CRAWSHAW** - Yes.

**Mr WILKINSON** - I know you have to cut your cloth to suit your costs, but surely there would be a situation where the first priority is to get the legislation right, and the funding comes later. Am I right in saying that the main thrust will be to get the legislation right, whether it can be funded straightaway or not?

**Dr CRAWSHAW** - Our focus is to get the right structure to the legislation, the right review points, right protections and I am quite focused in terms of protecting people's rights and making sure we have the capacity. As I have alluded to, I have already recruited the statewide clinical director who will assume the role of chief psychiatrist or chief civil psychiatrist, depending upon that language. He worked in the office of Chief Psychiatrist in Victoria before he came here so he is well versed in those sorts of issues. From our point of view, we are trying to see how we can get that functioning as quickly as possible and even some aspects of that in the balance of getting the legislation.

**CHAIR** - Is he currently employed?

**Dr CRAWSHAW** - Yes.

**CHAIR** - But not in that position because the position doesn't exist at the moment.

**Dr CRAWSHAW** - He started on 2 February.

**CHAIR** - In that position?

**Dr CRAWSHAW** - He started as my statewide Clinical Director, part of the improvements which, people may remember, the minister announced in terms of the funding for mental health. He is a very senior person, very focused in terms of the evidence-based practice and also has an academic interest in psychiatric epidemiology.

**CHAIR** - Does he have a name?

**Dr CRAWSHAW** - Professor Mark Oakley Browne.

**Mr DEAN** - I suppose many will say it doesn't matter much whether you get the act right or not; if you don't have the resources or the funding, what is really going to improve in the area of mental health.

**Dr CRAWSHAW** - Additional funding has been put into mental health and part of my task is to make sure that that funding is used effectively and does improve services. I did undertake a stocktake shortly after I took up my new role, to try to see where the issues lay and how we could address them. Some of it may require additional resources and, as people know, that is something which I have to talk to -

**Mr DEAN** - A lot of it is going to Ward 1E in Launceston.

**Mr WILKINSON** - I have asked a couple of witnesses this question already: under the Mental Health Act if a person is placed on an order within Tasmania, and that person jumps on a plane and goes to Victoria, Tasmania can't do anything. Is that right?

**Dr CRAWSHAW** - This comes back to interstate agreements and that is something which people are focused on in terms of trying to work through this issue. I guess the more high-profile cases have been around the forensic patient who hops on a plane and disappears.

**CHAIR** - Or the *Spirit*, they often hide on the *Spirit*.

**Mr WILKINSON** - Is that going to be addressed?

**Dr CRAWSHAW** - It is part of the current legislation. There is provision for the minister to enter into interstate agreements should that become necessary.

**CHAIR** - For forensic patients only or for all?

**Dr CRAWSHAW** - For all patients.

**CHAIR** - For all patients on an order?

**Dr CRAWSHAW** - Yes, as to what to do and how we move them back. I would have to say that just in the last week or two we have taken someone who became unwell in another State back and made arrangements to pick them up at the airport and provide them with the appropriate care.

**Mr WILKINSON** - Was that person on an order under the Mental Health Act in Tasmania?

**Dr CRAWSHAW** - I cannot give you the details off the top of my head but judging by the advice I was given, there were concerns that an immediate application of an order on this side might be necessary.

**Mr MARTIN** - Following Jim's previous question about drafting of the legislation and resource allocation, can you assure us that what you are proposing in the legislation is based on what you believe is best practice for Tasmania and is not influenced by what you think is affordable in relation to the State Budget?

**Dr CRAWSHAW** - If I was wanting to cut my cloth I wouldn't be making the proposals I am making. We are trying to get best practice legislation.

**CHAIR** - John, can I take you to pages 16-17 of your submission where you are talking about the dual responsibility for decision-making. You make the comment that the Guardianship and Administration Act and the Mental Health Act were intended to work together to form a continuum of protective and decision-making mechanisms. You talk about some of the consequences of having a dual decision-making system in place: 'The requirement for a decision to be made by two separate bodies works against the provision of holistic care and treatment. At best, requirement to refer to two pieces of legislation can mean more than one hearing for the person, resulting in unnecessary stress to patients at a time when they are acutely unwell and require ... to attend two hearings rather than one. At worst, the need for two separate authorisations in order to treat a person in an approved hospital may result in the person being detained without being treated, effectively preventing or limiting a person's ability to become well enough to be released into the community'. I think we understand that it would not be in the best interests of those patients if they have to go through that process, and also for the medical staff involved. Is this really highlighting a need to consider one piece of legislation that can provide the holistic approach to deal with these matters?

**Dr CRAWSHAW** - That is the intention of the draft legislation we are working on. We are focusing not so much on detention but on the treatment orders.

**CHAIR** - So the treatment and detention can come under one banner?

**Dr CRAWSHAW** - Yes.

**CHAIR** - When we look at what the guardianship and administration role can be, as well as looking after that person's treatment and detention you can also look at their accommodation once they leave hospital, their financial management and all those other things that there is a role with the Guardianship and Administration Board.

**Dr CRAWSHAW** - Potentially it could extend to that, but the majority of the acute detentions that we are talking about are around decisions to detain someone so that treatment can occur. The majority of what we are trying to do is to treat people to an extent whereby they can be restored to normal capacity to make decisions. The majority of people who fall within, in my experience, the mental health legislation do not need to go on and get administration orders for their property and do not necessarily need to get orders with respect to where they live. The focus is on trying to restore them to fully-capacitated decision making as quickly as possible.

**CHAIR** - There must be a percentage who require that because they take longer to recover and they may not go into remission - for want of a better description. Is there benefit in having that holistic and overarching responsibility under the one act? We talk about some certainty and in medical practice they know that there is this one act they have to go to and there are provisions in that one act to detain and treat someone who needs that level of intervention but within that same act there is the capacity for them or the people they are treating to get that broader holistic care.

**Dr CRAWSHAW** - Of the majority of the people we are talking about there is only a very small percentage who would require administration-type orders. The majority of people are needing intervention to maintain them within treatment. The way that we are thinking about couching the treatment orders involves all of the sorts of activity that we would need within the treatment and care of a person with a mental illness. Not to fix them to administration orders, but to the extent of ensuring that they get the rehabilitation, attend community appointments if necessary, if that's part of it, and get the required medication if that is part of it.

**CHAIR** - Falling under the Mental Health Act are the people who are on community treatment orders. These are people who are out in the community, having to live and function in the community. We are not just talking about the people who are detained in hospital.

**Dr CRAWSHAW** - No, that is why I am talking about treatment orders. The intention is that we were making treatment orders that then, if need be, could extend to them having an involuntary admission. So the focus is on the provision of treatment as distinct from the focus of the current act, which is on detention. There is quite a distinctive difference.

**CHAIR** - Yes, I understand what you are saying but my point is that when you have people who require orders, to ensure that they receive treatment - whether they be in hospital is not such an issue, but in the community certainly - having one piece of legislation that provides for all their needs in the community could have benefits.

**Dr CRAWSHAW** - Yes, and I guess what I am saying to you is that is how we have thought about crafting the Mental Health Act so that there is a continuance because treatment is what we really are focused on. I accept that that excludes the administration part orders but the other part, from my perspective, is that there is actually much more rigorous monitoring and independent checking and that capacity for us to actually maintain clinical standards.

**CHAIR** - I do not dispute for one second that the checks and balances are really important in that and have been lacking in the existing bill.

**Dr CRAWSHAW** - I also think that guardianship legislation tends to have a different focus and in order for us to actually increase that focus within the current Guardianship and Administration Act I think would require a total revamp of that act. That would require extensive consultation and making sure that we do not, in fixing up the mentally ill patient, inadvertently make it problematic for a whole range of other people who require it.

**CHAIR** - The comment has been made that the very fact that we have a Mental Health Act that discriminates against people with particularly that degree of mental health is discriminatory because we do not have a cancer act, we do not have a diabetes act, we do not have any-other-disease-you-would-like-to-name act. So the mere fact that it exists is discriminatory.

**Dr CRAWSHAW** - I think that is partly historical, I would agree, but also partly to do with the nature of mental illness in terms of it not only affecting a person's capacity to make decisions but also some of the needs to protect the public as well as the individual. I

think it is a very difficult balancing act and of course I can remember acts which basically enabled people to be held for very ill-defined reasons in hospital and the tests and thresholds were not there. They included people with dementia and all sorts of other reasons including holding people with epilepsy in mental health institutions.

**CHAIR** - We have moved on from there.

**Dr CRAWSHAW** - We have moved on from there. I come back to the fact that this is an amazingly intrusive involvement in someone's life. I think the level of intrusion that is allowed in legislation in terms of the mentally ill needs, I think, the proper checks and balances to make sure that it is dealt with. Because it is a fluctuating condition and because often the time period that someone is under the act is actually quite short, that places it in a somewhat different category from that of a number of the other people who end up under a guardianship-type process. While I would agree that there is a lot of work which may be needed in that other space, I just think that to delay this piece of legislation until we have resolved all of those other wider dilemmas means that we would be at risk of actually further denying some of the rights to the patients that fall within the Mental Health Act. There is another piece of work which we may get to in the fullness of time in terms of the evolution of the various protected legislations and we may end up with one piece of legislation but it may require quite extensive thinking about how you differentially apply that piece of legislation to people with a different nature and character of problems.

**CHAIR** - We have had evidence that such a review that would look at that sort of model would be extensive and very broad and certainly it could not happen in a short time frame, and I think we all accept that. There is no intention to stymie it and throw it out the door. I think we need to have this discussion about what is world's best practice and into the future.

**Dr CRAWSHAW** - I have looked at some of the reviews of what has happened in other places. Initially, for instance, the UK was going to end up with just one capacity type of legislation but eventually, because of some of these issues around risk and the protection of the public and so forth, they ended up with needing to continue with a piece of legislation called the Mental Health Act.

**CHAIR** - What is contained in that capacity act that could not sit comfortably in the eyes of the members of parliament there?

**Dr CRAWSHAW** - I am waiting to see as it is just in the process of going through. It will be really quite nice to know exactly how it is going to work out in practice.

**CHAIR** - It is still a work in progress at the moment?

**Dr CRAWSHAW** - My understanding is that they have actually passed it but I do not know that they have actually started implementing it, which is the critical issue.

**Mr DEAN** - If you go to page 19 of the submission in relation to the language and so on, it is actually an important issue because there is a certain amount of stigma attached to mental health and I think that probably stops a lot of people seeking assistance when they ought. I referred to the word 'detention' earlier today saying that there is no place really in

mental health acts and so on for the word 'detention'. It is good to see here that you have identified that the word 'detention' will be replaced with a more suitable word.

**CHAIR** - Have you found that word yet?

**Mr DEAN** - Probably 'admitted', 'admit' or 'admission'.

**Dr CRAWSHAW** - We are talking about involuntary admission or something like that. While we are talking about that we have been exercising our minds as to what, if anything, would be a more appropriate term than 'patient'. I was having discussions with representatives of a consumer group around that and they do not like 'consumer', necessarily, they do not like 'client'.

**CHAIR** - The same discussion occurs with women having babies. They are not patients, they are women having babies, but some people do not like to be talked about as a 'woman'. And they are not a 'patient, and 'client' has had a funny connotation that no-one likes because a lawyer has clients.

**Mr WILKINSON** - WHBs you call them - women having babies.

**Dr CRAWSHAW** - We are probably going to end up, because it is by no means resolved, with the consumer and care groups as to what is an acceptable alternative term.

**CHAIR** - You will not make everybody happy, I am sure.

**Dr CRAWSHAW** - We have actually applied our minds, as we are trying to go through the drafting process, to just do a sanity check and see whether this is actually setting up stigma in terms of the drafting of the legislation.

**CHAIR** - A sanity check is an interesting term.

**Dr CRAWSHAW** - It is.

**CHAIR** - How do you do a sanity check? You have probably done one on all of us sitting here and that is okay.

**Dr CRAWSHAW** - A vocabulary test then.

**Mr MARTIN** - The comment that was made this morning by one group of witnesses was that really the review is being conducted by medical people rather than lawyers who are advocates and therefore the new act is really going to be based on a medical model rather than a human rights model. Have you a comment to make on that?

**Dr CRAWSHAW** - I think that with due respect to lawyers, a lot of lawyers do not actually understand mental health legislation that well.

**Mr MARTIN** - Jim, are you listening to this?

**Mr WILKINSON** - I do not think I do. I do not think many practise in the field, do they, John?



**Dr CRAWSHAW** - Yes.

**Mr MARTIN** - I suppose what they are saying is that it has gone too far one way?

**Dr CRAWSHAW** - I would say we are trying to bend over backwards to actually ensure that there is a rights base to the legislation. In terms of actual thinking around rights-based legislation, in the time that I have been involved in these sorts of legislations here and in New Zealand, the whole issue of what constitutes someone's rights that need to be protected in these sorts of legislations has kept moving; so it is not a static thing. The learnings that have been gained from court rulings in other jurisdictions became applicable. In terms of medical practitioners, I used to have a book called *Trapski's Family Law* that I would look through for the legal interpretation of the latest case precedents when I was applying the Mental Health Act in New Zealand. Some of us who live and breathe mental health legislation become very skilled at understanding the nuances between clinical treatment, rights-based treatment, protection of the individual and who is being protected. We have had quite significant debates with the advisory committee and the drafting committee about how we get the balance right in protecting the rights of the patient and the public, as well as providing good treatment through a medical process. On our advisory committee we have had advocacy, the President of the Mental Health Tribunal, people who are involved in the drafting committee and we have incorporated legislative advisers who have legal training. It is not a question of us going one way or the other, it is about having a genuine debate about rights versus how we construct this so that treatment can occur.

**Mr MARTIN** - Do you have an expectation that the two groups you are referring to will be happy with the legislation?

**Dr CRAWSHAW** - I would hope that people are going to be happy, but my experience with mental health legislation is that because it is the art of compromising between often polarised views you may, at best, annoy everyone equally.

**CHAIR** - So the answer would be no?

**Dr CRAWSHAW** - No, I think people will genuinely see it as a movement forward. Will they think it is the final end point? No, because mental health legislation is constantly in evolution.

**Mr MARTIN** - One comment made in the Advocacy Tasmania submission -

**Dr CRAWSHAW** - I haven't read their submission so you will have to -

**Mr MARTIN** - I will quote one section in their introduction:

'Our organisation has presented options deemed far too progressive by the Tasmanian Government, including the repeal of the act and action founded in the argument that mental health legislation by its very existence is inherently discriminatory and unnecessary. It has developed and implemented its own innovative programs such as the Mental Health Tribunal Representation Scheme to guarantee that representation for people

appearing before the Mental Health Tribunal is more than a mere acknowledgment of the right but translates into an effective reality for people with psychiatric disabilities at a time when they are most vulnerable.'

Do you have any comment on that?

**Dr CRAWSHAW** - I value the input that Advocacy Tasmania has had in terms of protecting people's rights in advocating for a rights-based approach. I have enjoyed some of the debates we have had with them. Essentially, mental health legislation is about balancing a number of considerations: the rights of the individual, the expectations of the public and how we provide good care for people who have lost capacity or are posing risk. I think their viewpoint is important. We had strong views equally expressed by carers, consumers and members of the public. We have had 80 forums and 120 submissions in terms of that and we had a raft of views. I am not saying that their view is wrong; I think it is a valid viewpoint. Equally, carers have expressed to me a very valid viewpoint that they do not want to see their loved ones suffering unnecessarily and they wish us to have the capacity to intervene earlier so that they don't get to that suffering stage.

This is what I mean about the difficulty of mental health legislation. It is about trying to strike a right balance at this point in our society as to what is an acceptable level of restriction or intervention that still maintains the protection of the individual's rights. That is why it is a complex piece of legislation and that is why it is taking a bit longer to draft. It is also why we have had some of the intense debates which we have had about how we achieve that.

**Mr WILKINSON** - I mention this because the fellow who has written this has come to me on a couple of occasions about this. He says, 'Interstate, the order is not enforceable' - these are the mental health orders - 'but the patient typically has no medication, health declines and behavioural incidents attract police attention'. What he therefore is after is recognition of community treatment orders. He is saying that there is not at present. He says, 'Australia has nationwide recognition of drivers' licences, organ donor identifications, educational qualifications. Why is CTOs not yet recognised nationally when they assess people with mental illness?'

**Dr CRAWSHAW** - This comes back to the fact that there were different forms of legislation and people at different stages; it reflects precisely the stuff that you were raising from Advocacy Tasmania. While we have processes whereby we endeavour to make contact with counterpart treating services, we cannot control how they treat individuals. They may have different pressures on them, which means that they do not practise or are not able to be as assertive in terms of going out. It can often be that the carer - and it sounds like it's a carer -

**Mr WILKINSON** - No, it is a father.

**Dr CRAWSHAW** - The father is very genuinely concerned about his child's welfare - an adult child, I suspect.

**Mr WILKINSON** - Yes.

**Dr CRAWSHAW** - Yet when they are seen at the time they may not meet the criteria for intervention. We could write legislation that enables us to intervene in all sorts of people's lives in all sorts of ways, but that would be seen as very restrictive legislation because it is impinging on a lot of people's rights. We could write it very narrowly, which is the argument that some people have raised with us in terms of how the current act is interpreted so that you virtually have to be stabbing someone before you are regarded as a risk, and that equally gives us an issue. What we have tried to do is think about framing the test for mental illness within our legislation so that it genuinely respects a person's rights to make decisions when they are competent and when they are not posing a risk to themselves and others. We think about the fact that in the early stages of that slide into a severe mental illness you may have lost some of your capacity to take decisions at an earlier stage and wouldn't it be nice for us to intervene before we had to be draconian in terms of our interventions?

**CHAIR** - Early intervention would be voluntary in the majority cases if a person hasn't got to that severely psychotic state. They may have a mental illness, but in your experience would they be more likely able to have a rational conversation?

**Dr CRAWSHAW** - You can have rational conversations but sometimes at an earlier stage they may well be starting to lose the willingness to engage. Even with people with whom I have had a good personal working relationship I have had to use provisions of various legislation to actually get them into treatment early to prevent them from having long hospitalisations and loss of function. That is part of the discussion which we are having, which is how do you strike that balance. Why mental health legislation when there is guardianship legislation? Because it is probably more acute in this arena than it is within the guardianship-type arena. One of the issues in the past has been abuse of mental health legislation. Quite rightly people want to see protections built into the legislation to enable them to feel comfortable that the powers are not going to be misused.

**Mr WILKINSON** - This fellow went on - and his daughter was quietly severely affected - 'If uniform interstate recognition of CTOs had been in place four years ago, Cornelia Rau would have been identified in Queensland as a patient who had absconded from ordered treatment'.

**Dr CRAWSHAW** - That is certainly one view.

**Mr WILKINSON** - Do you think it is a fair view to have?

**Dr CRAWSHAW** - I can remember sitting and having debates with people as to whether or not there should be community treatment orders. This is the whole dilemma we have. It is a genuine issue where people have raised whether we can in some way sort out a commonality of legislation. I am sure that you would be aware that making commonality of legislation in one area often has knock-on effects in terms of other legislative frameworks within particular States as to whether or not you can get it up. A number of us had drawn from the model mental health bill that was developed in the 1990s but things have moved on from there. We are working on trying to get interstate recognition happening; how do we move the patients effectively across State borders when it is necessary? In my personal clinical experience I have often found services interstate extremely helpful in terms of intervening with people whom I have had concerns about and who had presented in these States. It cuts both ways.

**CHAIR** - You talk about clarity around involuntary treatment of persons with capacity and the significant risk of harm to a person or others. It almost goes to the issue of danger of involuntary treatment. How are these things actually assessed in practice? We have heard in evidence that there may be some medical practitioners who present a view that if a patient with a mental illness refuses treatment they are then deemed to be lacking capacity so they can then effect the treatment, as opposed to a person that may have capacity but has elected to refuse that treatment, though may be amenable to others. The fact that they have refused the doctor's recommendation means they are then deemed to be lacking capacity.

**Dr CRAWSHAW** - That was what I was alluding to before, that some of my colleagues may need some guidance around how the criteria are applied. Also, that is why we have been quite clear that there should be an independent review of those decisions because ultimately it is going to be the Mental Health Tribunal that will set the interpretation of standards. We are also focussing in the legislation about trying to define this whole issue of competency in a much clearer fashion, creating a presumption that the person is competent and proceeding from that point of view, and then very clearly defining when the criteria for intervention apart from that would apply. So that is part of the work which we have been doing in trying to craft the wording so that it gives much more legislative guidance than is currently the case.

**CHAIR** - So will there be a new Mental Health Tribunal under the act?

**Dr CRAWSHAW** - The intention is that there would be a tribunal of three members hearing most of the treatment orders.

**CHAIR** - So what are the qualifications required for those people?

**Dr CRAWSHAW** - One would be a legal member, one would be a medical member, and a sort of layperson. They would review whether the criteria are met and whether the treatment order requested is appropriate.

**CHAIR** - We have this little 'turf war' between the medical profession and the legal profession.

**Dr CRAWSHAW** - I have sat on tribunals like this. In New Zealand we had a mental health review tribunal which consisted of a doctor, a lawyer and a layperson who was a community member. By and large we functioned very effectively and we were able to reach consensus decisions most of the time, so I do not perceive it as a major problem.

**CHAIR** - It is good to hear that both will be represented because if we did not have them I think there would be a serious problem, from the evidence we have received.

**Dr CRAWSHAW** - That is one of the changes which we have been thinking of making, that the tribunal would consist of people who were appropriately skilled and qualified, including legally.

**CHAIR** - So currently one member of the Mental Health Tribunal can make the decision?

**Dr CRAWSHAW** - You could have a one-member tribunal, yes.

**CHAIR** - Which is an issue.

**Dr CRAWSHAW** - Yes.

**CHAIR** - So the proposed change would not allow that. There would have to be three members?

**Dr CRAWSHAW** - The full tribunal.

**CHAIR** - With the proposed changes there will be many more reviews where you will have two available doctors, two available lawyers - and God as well - and a couple of laypeople. When people get sick they take leave, mental health happens at any time, day or night.

**Dr CRAWSHAW** - It will be a matter for the registrar in conjunction with the president to maintain a sufficient supply of members. The current Forensic Tribunal has a medical member, usually the president of the Mental Health Tribunal or president of the Guardianship and Administration Board. We already have some tribunals with three-member representation. Part of the cost of the implementation is making sure that we have a sufficient supply of tribunal members.

**CHAIR** - Equally skilled and experienced.

**Dr CRAWSHAW** - That is right and without conflicts of interest.

**CHAIR** - How do you determine that?

**Dr CRAWSHAW** - I think that there are reasonably clear procedural issues that you can follow. For instance, the doctor involved could not have been involved with that person's case before.

**CHAIR** - That could be a problem in Tasmania.

**Dr CRAWSHAW** - It could be but not necessarily.

**CHAIR** - Patients from the north-west, for example, who are severely unwell often cannot be catered for on the north-west coast or even in Launceston so they end up in Hobart. They have often seen all the doctors along the way.

**Dr CRAWSHAW** - But there are, for instance, a number of other people who could sit on the tribunal, either from private practice or a medical member who may be someone who has done a lot of psychiatry in the past and is now in a semi-retired capacity.

**CHAIR** - Thanks, John, we have kept you long enough. There may be further questions that we need to ask after hearing from the rest of the witnesses so there may be a need to request the pleasure of your company again.

**Dr CRAWSHAW** - I am only too happy to help.

**CHAIR** - That is the right answer. Thank you.

**THE WITNESS WITHDREW.**