Chapter One

Overview of the legislation

The *Mental Health Act 1996* brings a number of changes to the way in which mental health services are delivered and reviewed. This chapter explains the foundations of the Act and provides a summary of its key features, including voluntary and involuntary hospital admission; medical and non-medical treatment and care in hospitals; community treatment orders; and the roles of the Mental Health Tribunal and official visitors.

Background

The *Mental Health Act 1996* has brought Tasmanian legislation into line with national and international standards in mental health, and was drafted following extensive community consultation. The legislation reflects modern approaches to the care of people who have a mental illness. The philosophy underlying the Act is drawn from both national and international principles. The national *Mental Health Policy and Plan* and the *United Nations Principles on the Care and Protection of People with a Mental Illness and for the Improvement of Mental Health Care* provide valuable background information on the aims of the legislation. National and international standards are incorporated into the legislation in sections 6 and 7.

International human rights

In 1991, the *United Nations Principles for the Protection of Persons with a Mental Illness and for the Improvement of Mental Health Care* was issued. These principles have provided the basis for the Tasmanian *Mental Health Act*. The objects of the *Mental Health Act 1996* (in sections 6 and 7) reflect the UN principles, and the provisions in the *Mental Health Act* were drafted to ensure that the UN principles were adhered to.

National policy and strategies

On a national level, one aim of the *National Mental Health Policy and Plan* was to ensure consistent legislation across Australia. The *Mental Health Act* provides for agreements to be entered into with other states that allow the transfer of people on orders across state boundaries. The *Mental Health Act* also draws from the *National Statement of Rights and Responsibilities* and the *Model Mental Health Clauses*. The *Mental Health Act* assists Tasmania in meeting national standards for mental health legislation, particularly in regard to the rights of people affected by mental disorders and/or mental health problems.

The Tasmanian legislative framework

The provisions in the *Mental Health Act 1963* that dealt with people with decision making disabilities and those who came within the ambit of the justice system, have been separated out into distinct pieces of legislation. These related Acts are described briefly below:

Mental Health Act 1996

This Act – which is an Act to make provision for the care and treatment of persons with mental illnesses and for safeguarding their rights.

Guardianship and Administration Act 1995

The *Guardianship and Administration Act 1996* established the Guardianship and Administration Board. The Board now deals with financial and lifestyle matters for people with disabilities that affect their ability to make decisions, and people with an intellectual disability are not covered by the *Mental Health Act* unless they have a co-existing mental illness. There are special provisions under the *Mental Health Act* for applying to the Guardianship and Administration Board for consent to medical treatment for a mental illness.

Criminal Justice (Mental Impairment) Act 1999

The *Criminal Justice (Mental Impairment) Act* makes provision for the detention and treatment of people who are unfit to be tried or found not guilty by reason of insanity. The Act also deals with the release of such persons.

Sentencing Act 1997

Under this Act people who are found guilty of offences may become subject to orders under Mental Health legislation.

Further information on these Acts and other related information is available in Chapter 10.

The foundations of the Act

The foundations for the *Mental Health Act* are established in the first few sections of the Act. It is there that the following may be found:

- the definitions used within the Act (section 3);
- the definition of mental illness (section 4);
- the concept of the person responsible (section 5);
- the objects of the legislation (section 6);
- the principle of minimum interference with the person's rights (section 7).

Interpretation – section 3

Section 3 of the Act defines the key terms and concepts. As a general rule, the bodies or positions (such as approved medical practitioner) are defined in this section. Other words in the Act that may have an expanded meaning, such as 'seclusion,''restraint,''harm' and 'spouse' are also defined in this section. If a word is not defined, then in general, the ordinary, common-sense meaning applies. A glossary has been included at the front of this guide to clarify commonly used terms.

The definition of mental illness – section 4

To use the powers in the Act that relate to involuntary admission to hospitals, the initial question is whether the person has, or is believed to have a mental illness as defined in section 4. This is the preliminary question that must be answered by all practitioners as it establishes the authority to use powers conferred by the legislation.

Under the *Mental Health Act*, a mental illness is defined as a mental condition resulting in:

- serious distortion of perception or thought; or
- serious impairment or disturbance of the capacity for rational thought; or
- serious mood disorder; or
- involuntary behaviour or serious impairment of the capacity to control behaviour.

The Act also specifies that a diagnosis of mental illness may not be based solely on a person's antisocial behaviour; their intellectual or behavioural nonconformity; their intellectual disability; or their intoxication by reason of alcohol or a drug.

It should be noted that the definition of mental illness is specific to the operation of the Act. It is not intended to define or prescribe service provision in the area of voluntary admission which may well relate to wider definitions such as mental disorder.

The person responsible – section 5

Once a person is admitted to hospital as an involuntary patient, the next question may be identifying the person responsible for the purposes of consent to medical treatment.

It is important to know who is the person responsible because they play an important part in the care of the mentally ill person. The person responsible can apply for a person to be placed on an involuntary treatment order and they can also consent to some medical treatments for the patient, if the patient lacks capacity to consent (see Chapter 5 for more information on consent to medical treatment). If there is a person responsible, this person must also be given a statement of the patient's legal rights. The Act distinguishes between people who are under 18 and those over 18 in determining who is the person responsible, as follows:

People under 18

If the person is under 18, the person responsible is her or his spouse, and if there is no spouse then the person's parent. If the person is a ward of the State, the Director for Community Welfare (ie the Secretary of Department of Health and Human Services [DHHS]) is taken to be the person responsible for him or her. Once the *Children, Young Persons and Their Families Act 1998* commences, if there is a

care and protection order made for the person under that Act, the Secretary of the DHHS or other guardian listed in the order is taken to be the person responsible.

People 18 years and older

If the person is 18 years or over, the Act gives a list of people who may be considered the person responsible. This list is in order of priority, that is, the person who is first on the list should be approached first and so on. The order of priority is as follows:

- the person's *guardian*. This is defined in section 3 as a person appointed as a guardian or an enduring guardian under the *Guardianship and Administration Act*.
- the person's *spouse*. This includes a de facto spouse or same sex partner. The spouse and must have a close and continuing relationship with the person and cannot themselves be under guardianship.
- the person's *carer*, where the carer provides or arranges domestic services and support on a regular basis and is unpaid. Receiving a carer's pension is not relevant as payment. Where the person lives in a hospital, nursing home or other residential facility and is cared for in the facility, the person who cares for them is not the person responsible in the absence of other factors. In this situation the person responsible would be the person who provided care before the patient moved to the hospital, nursing home or other facility.
- a *close friend or relative*, where there is both a close personal relationship through frequent personal contact and a personal interest in the person's welfare, on an unpaid basis.

The objects of the Act – section 6

National and international standards are embodied in the objects of the legislation. Objects of legislation are principles which guide the interpretation of the Act. The legislation will be interpreted in a way that gives the greatest effect to the objects, and they are therefore the central guide to the Act. When there are two or more possible ways for a section in the Act to be interpreted, it is useful to go to the objects and see which interpretation best meets these objects.

The objects of the Act are both practical and aspirational. The practical objects can help decide the appropriate action in any given circumstance, and the aspirational objects provide a vision for the care we would like to see provided to all people with a mental illness.

The objects of the Act are:

- to provide for the care and treatment of persons with mental illnesses in accordance with the best possible standards while at the same time safeguarding and maintaining their civil rights and identity; and
- to ensure that involuntary patients with mental illnesses are provided with appropriate information about their statutory and other rights; and
- to provide for the making and review of orders for involuntary admission, treatment and detention of involuntary patients with mental illnesses; and
- to provide for the monitoring and review of the mental health system; and
- to ensure that the services provided for persons with mental illnesses are equitable, comprehensive, co-ordinated, accessible and free from stigma, and in particular to ensure that standards of care and treatment for those persons are at least equal to the standards of care and treatment for physical illnesses and disabilities; and

- to promote recognition in the community of the rights of persons with mental illnesses to the best possible standards of care and treatment; and
- to reduce the adverse effects of mental illness on family life; and
- to encourage and contribute to the highest possible standards of:
  (a) care and treatment for persons with mental illnesses; and
  (b) research into the cause of, and treatment for, mental illnesses; and
- to encourage the care and treatment of persons with mental illnesses in the community and to design and co-ordinate an integrated system of community support services for persons with mental illnesses who are being cared for in the community.

The principle of minimum interference with civil rights – section 7

Section 7 of the Act provides a clear direction to all people who use the *Mental Health Act*. It states that in exercising powers conferred by the Act in relation to an involuntary patient, the following principles must be observed:

- restrictions on the liberty of the patient and interference with the patient's rights, dignity and self respect must be kept to the minimum, consistent with the need to protect the patients and others;
- effect must, if practicable, be given to the patient's wishes so far as that is consistent with:
  (a) the patient's best interests; and
  (b) the need to protect the patient and others.

Voluntary admission

Section 19 of the *Mental Health Act 1996* defines voluntary admission as being admission to hospital with the person's consent, or with the consent of a parent or guardian if the person is under 14 years of age. If a person under 14 resists admission to the approved hospital, they can not be admitted as a voluntary patient and consideration must be given to the use of an involuntary order.

Refusal of admission and second opinions – sections 20 and 21

If a doctor refuses to admit a person as a voluntary patient, they must tell the person why admission is refused and refer them to other facilities which may be appropriate.

Provision is made in the Act for a second opinion if a person is refused admission on the grounds that they do not have a mental illness which can be treated at the hospital (section 21). In these circumstances, the person must be referred to an approved medical practitioner, who can confirm the order not to admit the patient or may request that the patient be admitted.

Discharge from hospital – sections 22 and 23

The right of a voluntary patient to discharge him or herself at any time is stated in section 22. If a voluntary patient seeks to discharge him or herself from hospital, a medical practitioner or an approved nurse may detain the person for up to four hours, to allow for the examination of the person and to have a decision made about whether an order should be made for the involuntary hospitalisation of the person (section 23).

Involuntary admission

The Act creates two orders that allow for involuntary hospitalisation – an initial order (IO) and a continuing care order (CCO). As with the *Mental Health Act 1963*, an application by a relative/carer or an authorised officer is required. The difference with the *Mental Health Act 1996* is that the relative/carer **need not be the next of kin**, but can be a carer or a close friend or relative as defined in section 5.

The criteria for detention as an involuntary patient – section 24

A person can only be placed on an initial order or continuing care order if they meet the criteria for detention as an involuntary patient. That is:

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

Initial orders – sections 24 – 27

An initial order allows for involuntary admission for up to 72 hours. However the person must be released after 24 hours if an approved medical practitioner has not examined them and confirmed the order during that time.

Continuing care orders – sections 28 – 30

A continuing care order allows for involuntary admission to an approved hospital for up to six months and can be made if the person is already on an initial order or a community treatment order.

Before making an order for involuntary hospital admission, the treating team must have regard to what form of treatment will be the least restrictive alternative (see the objects and principles underpinning the Act in Chapter 1, above).

Medical treatment and care in hospital

Under the Act, medical treatment can only be given with the person's informed consent, or if the treatment is authorised by or under the *Guardianship and Administration Act*. Under the *Guardianship and Administration Act*, the person responsible may provide consent for the patient in some situations.

Informed consent – section 33

The *Mental Health Act* defines informed consent in section 33. Before a valid consent can be given, the medical practitioner must give the patient a clear and full explanation of the treatment, and the patient must be able to understand the general nature and effect of the proposed treatment, and they must

freely and voluntarily consent. The area of informed consent is complex, and more detail is provided in Chapter 5.

Non-medical treatment in hospital

Part 6 of the *Mental Health Act* deals with the non-medical treatment of involuntary patients in approved hospitals. Non-medical treatment includes the use of physical restraint and seclusion, leave of absence and transfers of involuntary patients between approved hospitals.

Seclusion and bodily restraint – sections 34 and 35

Preconditions for seclusion and restraint are set out in sections 34 and 35 of the Act. Instances of seclusion and restraint must be recorded and the senior approved medical practitioner must send a report to the Mental Health Tribunal every month. More information on the use of seclusion and restraint is provided in Chapter 6.

Leave of absence – section 37

Involuntary patients can be given leave of absence if this is approved by the treating psychiatrist. The patient must be given a written statement of the terms and conditions on which the leave of absence has been approved. The patient must also be given notice in writing if the leave is revoked.

Transfer between hospitals – section 39

An involuntary patient may be transferred from one approved hospital to another if the transfer is necessary or desirable for the care or treatment of the patient or for the purpose of avoiding or minimising risk to others. The controlling authority of each hospital must agree before a transfer can take place.

Community treatment orders

Community treatment orders (CTOs) provide a less restrictive alternative to hospital admission for people who still require involuntary treatment for their mental illness. A community treatment order can be made for up to 12 months and can require the person to attend appointments as an outpatient and/or to submit to treatment as decided by their treating doctor.

Criteria for making CTOs – section 40

As with orders for involuntary hospitalisation, the *Mental Health Act* provides strict criteria which must be met before a CTO can be made. These are that:

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

- the order is necessary to ensure that the illness is properly treated; and
- facilities or services are available for the care and treatment of the person.

Hospital treatment and CTOs

A community treatment order does not in itself allow the person to be involuntarily hospitalised, but the person can go directly onto a continuing care order after an assessment by a medical practitioner and an approved medical practitioner. If the person is hospitalised for under three months, the community treatment order is suspended while they are in hospital, and revives on discharge. If the person is hospitalised for over three months the order lapses and another community treatment order needs to be made.

Information requirements

The Act states that people must be given a written statement of legal rights when an order under the Act is made. This statement must also be given to their relative or carer who is called the person responsible. The people who come within this definition and the order in which they should be approached are given in section 5 of the Act (see also Chapter 1, above).

In addition, patients must be given a statement of their diagnosis and treatment when this has been determined. There is an obligation to provide information in a way that is understandable to the patient if this is possible (see also Chapter 11). If information is withheld from the patient, the Mental Health Tribunal must be notified within 48 hours. The senior approved medical practitioner is responsible for ensuring that the Tribunal is notified if information is withheld, and a standard form has been developed to assist practitioners.

Review of involuntary treatment

The role of the Mental Health Tribunal

Under the new Act, the Mental Health Tribunal must review continuing care orders and community treatment orders within 28 days of the order being made. The Tribunal can revoke, vary or confirm these orders. The Tribunal can review orders on the application of either the person who is the subject of the order or a person who has an interest in their welfare.

The Tribunal will also review:

- the use of seclusion in approved hospitals;
- the use of restraint in approved hospitals;
- the withholding of information from a patient or person responsible; and
- decisions to transfer a patient or to refuse to transfer a patient under section 39 of the Act.

Official visitors

The new Act introduces an official visitor scheme, following the recommendation in the *Burdekin Report*. Most other States and Territories have an official visitor program in some form. The role of the official visitors is to visit mental health facilities and examine the physical environment and care of people with a mental illness as well as to investigate suspected breaches of the Act and complaints by consumers.

The official visitors must visit approved hospitals at least once a month, and can require the senior approved medical practitioner to produce records relating to the admission, care and treatment of patients, arrange interviews with patients, or answer questions about the care or treatment of patients. Hospitals are required to inform the official visitors of any requests by patients to see them. Official visitors must report any suspected contravention of the Act to the Mental Health Tribunal.