



ANNUAL REPORT

2005-06

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## The Mental Health Tribunal

The Act provides that the Tribunal is to be constituted by a President and at least five other members. One of the other members is to be the Deputy President and one is to be an approved medical practitioner. Schedule 1 of the Act governs the appointment of members. The Governor in Council appoints all members.

The President must be a qualified legal practitioner of not less than seven years standing and is the only contractual member of the Tribunal. The position of President is 0.5 of a full time position and the President is appointed for five years.

All members, except the President, work on a sessional basis.

The Act requires that one of the members is an approved medical practitioner.

The Act does not stipulate the qualifications of the other members of the Tribunal, however they can be roughly divided into the following categories:

- legal members;
- mental health practitioners; and
- community members.

A list of members with a brief outline of their qualifications and previous experience is set out in Appendix 1.

## 2005 – 2006 MHT - In Summary

During the period the 1 July 2005 to 30 June 2006 The Mental Health Tribunal,

- scheduled for hearing 505 mandatory reviews and 34 applications to review;
- completed 227 reviews;
- confirmed the patient's involuntary status on 119 occasions;
- discharged the patient from their involuntary status on 35 occasions;
- varied the order relating to the patient on 49 occasions;
- conducted two reviews under section 37 of the *Criminal Justice (Mental Impairment) Act 1999*;
- declined to issue a certificate that the person subject of the *Criminal Justice (Mental Impairment) Act 1999* should be released from detention on both occasions;

- conducted hearings in 10 venues around the State;
- articulated and promoted the Tribunal's view on amendments required to the *Mental Health Act 1996*;
- continued a program of education on the role of the Tribunal through information and advisory seminars for mental health care professionals;
- continued the professional development of members through newsletters;
- continued in the training of students to appear as advocates for patients in hearings; and
- handed over jurisdiction for forensic matters to the new Tasmanian Forensic Tribunal

## **MHT - Jurisdiction**

On 1 November 1999 the *Mental Health Act 1996* (the Act) commenced operation.

The Act establishes a balance between the civil liberties of a person suffering a mental illness and the right of the public to live in a safe and secure environment.

The Act allows the civil liberties of a person suffering a mental illness to be curtailed by the making of an Initial Order, a Continuing Care Order, a Community Treatment Order, or an Authorisation for Temporary Admission.

An Initial Order allows a person to be taken to and detained in an approved hospital for up to 72 hours if, they appear to be suffering a mental illness and if, as a result of that illness, they are a significant risk of causing harm to themselves or others and their detention is necessary to protect them or others from that harm.

A Continuing Care Order allows a person to be detained in an approved hospital against their will, for up to 6 months, if they appear to be suffering a mental illness and if, as a result of that illness, they are a significant risk of causing harm to themselves or others and their detention is necessary to protect them or others from that harm.

A person on a Continuing Care Order can whilst on that order be given leave of absence from the hospital to live in the community. A person placed on a leave of absence is required to abide by conditions placed on their leave and if they fail to so comply can immediately be returned to the hospital. A leave of absence is a short-term measure to allow the treating team to assess the patient's ability to survive in the community and as a result the need for further detention in an approved hospital.

A Community Treatment Order allows a person who is suffering a mental illness and, as a result of that illness, is a risk to themselves or others, unless the mental illness is treated, to remain in the community so long as they abide by the conditions stipulated by the approved medical practitioner who made the order.

If a person placed on a Community Treatment Order fails to comply with a condition of that order, regardless of all reasonable steps having been taken by the treating team to procure their compliance, and there is, a significant risk that their mental health will deteriorate or has deteriorated as a result of their noncompliance they can be taken into protective custody and detained in an approved hospital for up to 14 days.

Section 48 of the Act established the Mental Health Tribunal (the Tribunal).

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

- orders to detain a person as an involuntary patient in an approved hospital (Continuing Care Orders);
- the making of a community treatment order (Community Treatment Orders); and
- an authorisation to return a person subject to a Community Treatment Order to hospital against their will (Authorisation for Temporary Admission).

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

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

The Tribunal is empowered by the Act to:

- review decisions and orders to admit persons as involuntary patients in approved hospitals;
- carry out periodic reviews of the detention of involuntary patients in approved hospitals;
- review the making of, and carry out periodic reviews of, community treatment orders; and
- receive reports on the use of restraint, seclusion and the withholding of information under section 45(3) and, if thought fit, to issue directions or guidelines for regulating any such matter.

The reviews carried out by the Tribunal are either mandatory reviews or as the result of an application received from or on behalf of the patient.

The Tribunal does not review Initial Orders. Until 20 February 2006, (under section 37 of the *Criminal Justice (Mental Impairment) Act 1999*), the Tribunal was also required to review the detention of a person in a special facility under a restriction order. A person so detained is a person who has been found not guilty of an offence on the ground of insanity

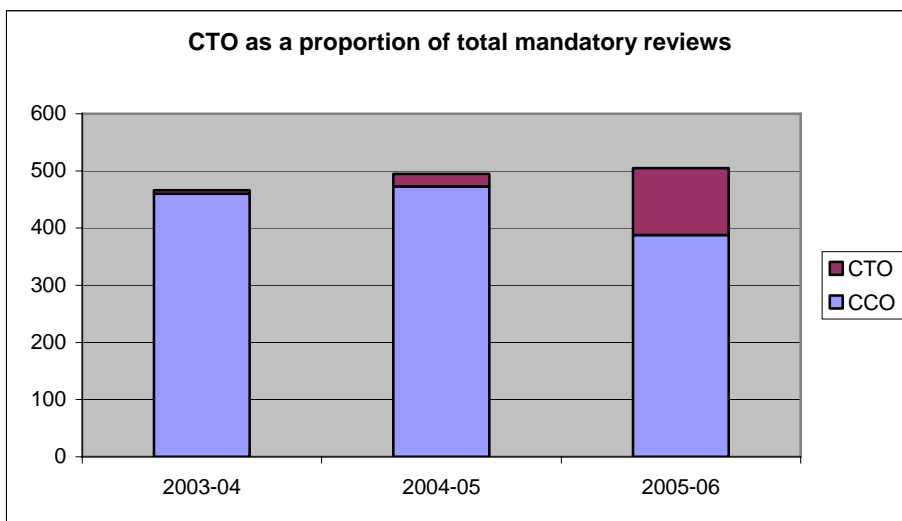
or a person who has been found unfit to stand trial. Such orders were to be reviewed 12 months after the order was made and at least once every 12 months after that.

On the 11<sup>th</sup> July 2005 the Act was amended to allow the Tribunal to review an Authorisation for Temporary Admission at the request of the patient, the person responsible or another person who has an interest in the welfare of the patient.

## MHT - Reviews of orders

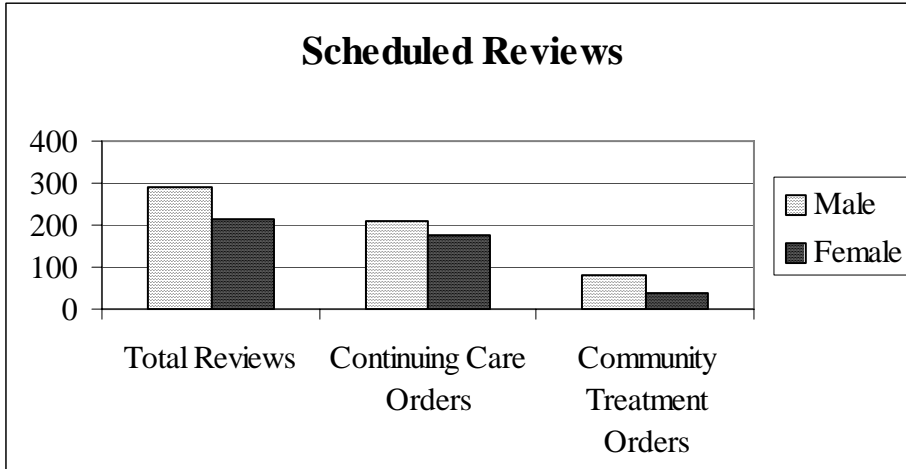
### SCHEDULED REVIEWS

There were 505 mandatory reviews scheduled by the Tribunal during the year, of which 388 (77%) related to persons detained under a Continuing Care Order and 117 (23%) were for people under Community Treatment Orders. Two reviews were related to orders made under the Criminal Justice (Mental Impairment) Act.



The use of Community Treatment Orders as a percentage of involuntary orders increased from 1% of orders in 2004-05 to 23% in 2005-06. This was a direct result of the amendment of the Act on the 11<sup>th</sup> of July 2005 to allow for authorised temporary hospital admissions if a patient failed to comply with the conditions placed upon their Community Treatment Order.

Of the mandatory reviews 290 were for male patients and 215 females. Male patients accounted for 68% of patients on Community Treatment Orders, but only 54% of those on Continuing Care Orders.



## APPLICATIONS FOR REVIEW

Section 52 of the Act enables a person subject to an order, or a person on their behalf, to apply to the Tribunal for a review of that order.

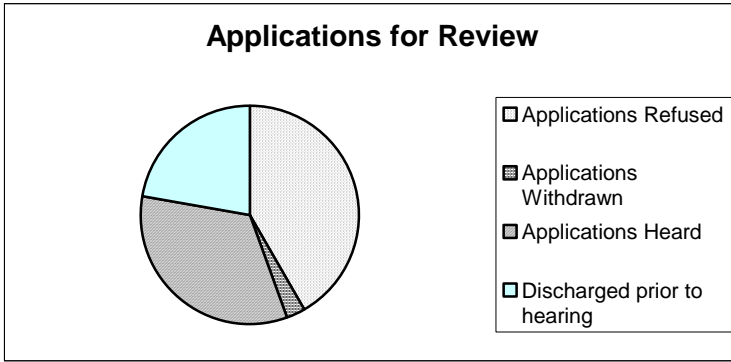
34 applications for review were received from, or on behalf of, patients. Of these, 30 related to Continuing Care Orders (19 males and 11 females), 3 to Community Treatment Orders (1 male, 2 females) and one male patient requested a review of an Authorised Temporary Admission Order.

Section 52(5) allows the Tribunal to refuse an application for review of a Continuing Care Order or a Community Treatment Order if the period that has elapsed since the last review is three months or less, or there has been no material change in circumstances since the last time the Tribunal reviewed the applicant's order. The Tribunal refused to hear 15 applications.

## COMPLETED REVIEWS

Of the 505 mandatory reviews scheduled under the Act, 227 proceeded to hearing. 261 were cancelled prior to the hearing due to the patient being discharged from the order, a further 39 Continuing Care Orders were discharged by the making of a Community Treatment Order. Nine orders were declared invalid.

Of the 34 applications for review, 12 proceeded to a hearing. 15 were refused, 1 hearing was cancelled due to withdrawal of the application by the patient, eight were cancelled by discharge prior to hearing.

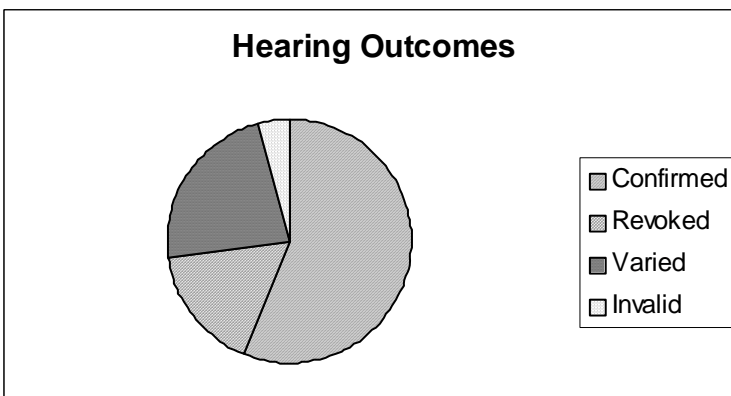


## OUTCOME OF REVIEWS

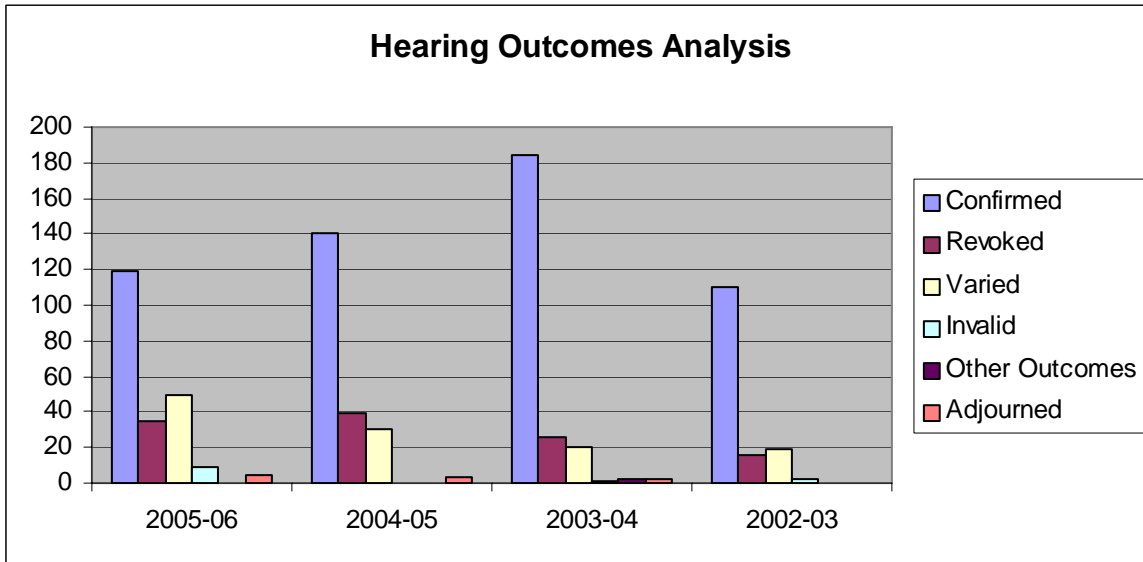
Of the mandatory reviews completed under the Act the Tribunal revoked the order and discharged the patient from involuntary status on 35 occasions, or in 15% of cases. 20 revocations related to Continuing Care Orders, 14 to Community Treatment Orders and one to an Authorised Temporary Admission.

In 2002-03 the Tribunal revoked the Order in 10% of cases, in 2003-04 12% of orders were revoked and in 2004-05 18%. The increase in revocations in 2004-05 reflected the increased use by the hospital of a Continuing Care Order with a leave of absence when it was not intended that the patient would be detained in the hospital following discharge and it was considered that a Community Treatment Order with no ability to return the patient if they breached the conditions of the order was not a sufficient safety net for the safety of the patient and the public. These orders were revoked, as their use in these circumstances was contrary to the intention and scheme of the Act.

The decrease in revocations this year is a further reflection of the amendments of the 11<sup>th</sup> July 2005



119 orders were confirmed (55%) whilst 49 (23%) were varied by the Tribunal changing the period of time that the order remained in force or the conditions of the order.



12 applications for review proceeded to a hearing. Of these, 6 orders were confirmed, four were revoked and two were varied.

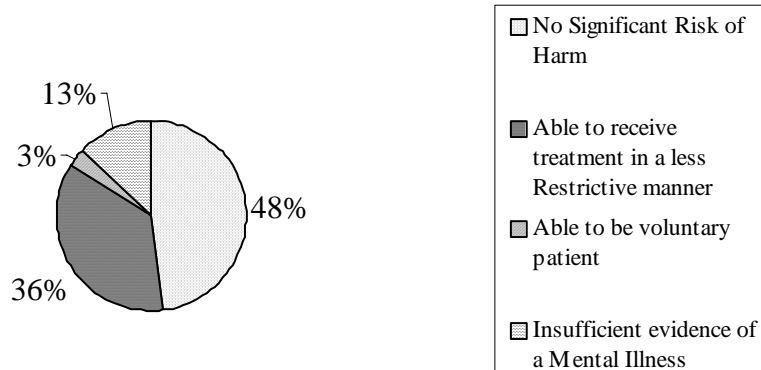
Two reviews were heard pursuant to the *Criminal Justice (Mental Impairment) Act 1999*. The Tribunal refused to issue a certificate to allow the patient to apply to the Supreme Court for the lifting of the restriction order in both of these matters. The Mental Health Tribunal's jurisdiction to hear these matters ceased with the creation of the Tasmanian Forensic Tribunal on the 20<sup>th</sup> of February 2006.

## REASONS FOR REVOKING ORDERS

Of the 35 orders revoked by the Mental Health Tribunal, 48% of the revocations were based on the Tribunal's finding that there was insufficient evidence before the Tribunal of a significant risk of harm to the patient or others if the order was not in place. In a further 36% of cases the Tribunal revoked the order, as there was a less restrictive alternative available for the patient that allowed for the safety of the patient and the public.

In 13% or 4 cases the order was revoked because, the Tribunal could not be satisfied by the evidence presented, that the person suffered a mental illness.

## Reasons for Revoking Orders



## Hearings of the Mental Health Tribunal

The Act gives the following procedural directives:

- The Tribunal must in hearing any matter act according to good conscience having regard to the objects and principles specified in sections 6 and 7 but without regard to technicalities or legal forms (56(1)(a));
- The Tribunal is bound by the rules of natural justice (56(1)(b));
- The Tribunal must avoid unnecessary formality (56(2));
- The Tribunal is not bound by the rules of evidence but can inform itself as it thinks fit (58(1));
- Evidence may be given orally or in writing or partly orally and partly in writing. Evidence may be given on oath or by statutory declaration (58(2));
- The Tribunal may, of its own motion or on the application of any party, direct the Registrar to serve on any person a summons to appear before the Tribunal to give evidence or to produce documents (59(1));
- The Tribunal may require the controlling authority of an approved hospital to provide it with a report or copies of records about the care or treatment of the patient (60);
- The Tribunal may require a patient to submit to a medical examination by a specified medical practitioner (61(2));
- The Tribunal may visit and interview in private any patient by or in respect of whom an application has been made (62); and
- Proceedings before the Tribunal are closed to the public but the Tribunal may direct that particular proceedings (or parts of proceedings) are to be open to the public (64).

The Act provides a framework for Tribunal procedures but also gives it considerable discretion in determining the manner in which proceedings are to be conducted. In exercising its discretion the Tribunal strives to achieve a balance between the need to thoroughly deal with questions of liberty, and minimising the disruption to the therapeutic relationship between patients and their treating team.

Scheduling of Tribunal members to conduct hearings is at the discretion of the President. In choosing the member or members of the Tribunal the President has regard to the nature of the matters to be considered, and the knowledge and experience of the members.

## **MHT Hearings Conducted**

229 hearings were conducted at 122 sittings of the Tribunal during the year. 96 sittings were by a three member Tribunal and 26 by a 1 member Tribunal. In 11 of the 26 single member Tribunals the member sitting alone was the President, on 3 occasions in Hobart Ms. Barker sat alone, Ms. West on 1 and Mr. Wise on 1. In Launceston Ms. Hill sat alone on 4 occasions and in Burnie, Mr. Marriott on 4 occasions and Mr. de Jong and Ms. Brooks once each.

In all three member Tribunals the President has aimed wherever practicable to have a legal member, a mental health practitioner member and a community member.

## **TIMEFRAMES FOR THE SCHEDULING OF HEARINGS**

The Act provides that the hearing of the matter must take place:

- Within 28 days after the making or renewal of a Continuing Care Order or a Community Treatment Order (s52);
- Within 28 days of the date on which an involuntary patient is transferred to Tasmania under Part 12 of the Act (s52(3));
- Within 3 days of the admission of an involuntary patient to a secure mental health unit (s52(3A));
- Within 21 days of receiving an application requesting a review from or on behalf of the patient subject to a:
  - Continuing Care Order
  - Community Treatment Order or
  - Transfer order
- Unless another review is to be heard within 35 days s54(2).
- Within 7 days of receiving an application requesting a review of Authorisation for Temporary Admission.-.s54(2)

Review hearings were scheduled within the statutory time frame in 99% of cases. The remaining 1% (seven cases) did not meet the statutory time requirement because the Tribunal received late notification that an order had been made.

## NOTICES OF HEARING

Section 54 of the Act requires reasonable notification be given to the patient, the person responsible and where relevant the approved hospital.

Notices of hearing are forwarded to the patient and the approved hospital at least seven days before the hearing.

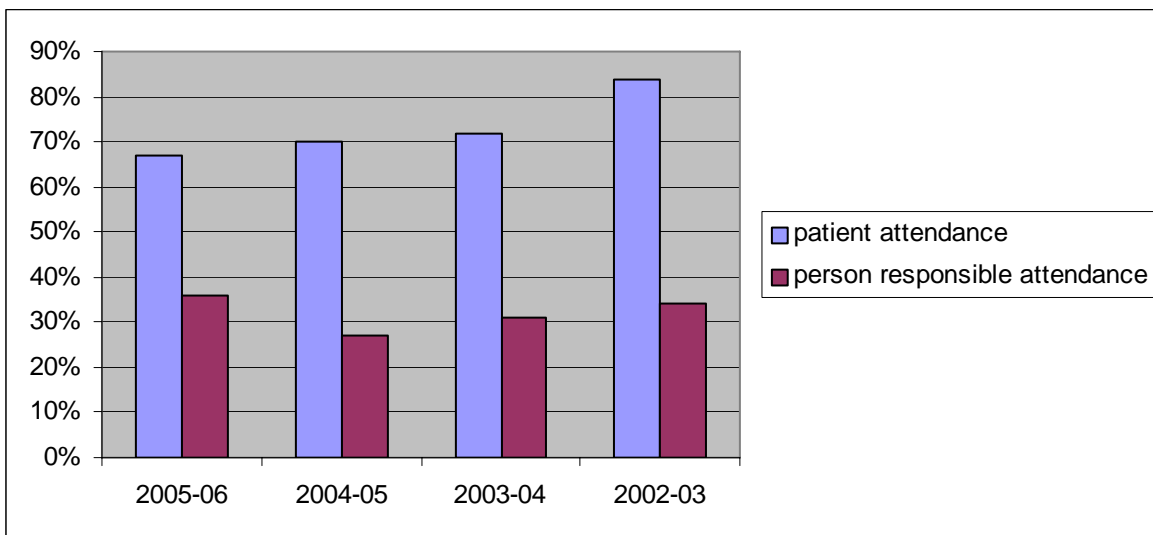
In order to forward notification to the person responsible the Tribunal is reliant upon information received from the hospital to identify the appropriate person. In many cases the 'person responsible' remains unknown to the Tribunal or the person nominated by the hospital is in fact a person who no longer has contact with the patient. The Tribunal forwards notices of the hearing to the person nominated by the hospital as the 'person responsible'.

## ATTENDANCE AT HEARINGS

Although the Tribunal encourages patients to attend their reviews and take an active role in the hearing of their matter, patients are not obliged to attend.

Whenever a patient is not in attendance the Tribunal confirms that the patient has been notified of the hearing and, where possible, verifies that it is the patient's choice not to attend, before commencing the hearing.

On 144 occasions (66%) the involuntary patient exercised his or her right to attend and on 77 occasions the person responsible attended



## **REPRESENTATION AT HEARINGS –**

Section 57(3) of the Act gives all parties appearing before the Tribunal a right to be represented by a legal practitioner or other person.

In the year under review 42% of patients appearing before a Tribunal were represented by an advocate from the Mental Health Representation Scheme and 62% had been given advice and support, via the telephone, by an advocate from this scheme, prior to hearing.

1 patient was represented by a lawyer.

No other parties were represented by a lawyer or other person in any hearing.

## **VENUES OF HEARINGS**

The Tribunal conducted all hearings for a Continuing Care Order at the venue in which the patient is currently receiving treatment. Hearings for patients subject to a Community Treatment Order in the South of the State were held at the Tribunal's premises. The Tribunal sat at 10 venues around the State during the year.

## **MHT - Other Achievements and Issues**

### **REGISTRAR TRAINING**

The Tribunal has devised a training programme for registrars and other medical professionals who appear before it. The aim of the training is to enhance the ability of the practitioners to present material to the Tribunal in a meaningful manner. The training outlines the role and function of the Tribunal, relevant sections of the Act, the interpretation of key words in the legislation, looks at the amendments to the Act and their impact upon hearings, discusses 'what is evidence?' and relates each of these areas to the hearing process adopted by the Tribunal.

The first training was held in Hobart in August 2005. This training will be offered on an annual basis.

### **REVIEW OF LEGISLATION**

#### *The review of the Mental Health Act 1996.*

In 1996 when the Mental Health Act was passed by Parliament the then Minister for Health made an undertaking to the Parliament that the Act would be reviewed within 12 months of the Proclamation of the Act.

The Act was proclaimed on the 1<sup>st</sup> November 1999. The review of the Act has still not been commenced.

#### *Amendments to the Act to allow the conditions of a Community Treatment Order to be reviewed*

On July 11<sup>th</sup> 2005 the Act was amended to allow a patient who has not complied with the conditions of his/her Community Treatment Order to be returned to an approved hospital and detained there as an involuntary patient for a maximum period of fourteen days. The Tribunal had advocated for this amendment since November 2000.

As a result of the amendment the percentage of patients subject to a Community Treatment Order has risen from 1% in 2004/05 to 23% in 2005/06.

One patient has sought a review of the Authorisation for Temporary Admission that arose from an alleged breach of the conditions placed upon his Community Treatment Order. On this occasion the Tribunal revoked the authorisation, as the patient had not in fact breached the terms of the order.

The Tribunal has on each occasion it has reviewed a Community Treatment Order reviewed the conditions placed upon that order to ensure that the patient is aware of the obligations placed upon them by the order, that the conditions of the order are in clear and unequivocal language and are in fact conditions with which the patient can comply.

This review of the conditions of the order is aimed at educating practitioners in the appropriateness of conditions and the impact that the terminology of the condition may have upon the confirmation of an Authorisation for Temporary Admission during the life of the order.

***The involuntary detention of patients without treatment and the Tribunal's inability to determine treatment issues.***

The Tribunal continues to have concerns regarding its inability to determine treatment issues. In 2005/06 34 patients, or 6.7% of persons placed on an involuntary order, also required an order for medical treatment.

The Mental Health Tribunal is not empowered under the Act to make an order for medical treatment. In all other jurisdictions in Australia the Tribunal not only determines detention but also determines treatment. Treatment orders in Tasmania are made by the Guardianship and Administration Board of Tasmania.

Section 32 of the *Mental Health Act* deals with medical treatment for patients in approved hospitals that refuse treatment or are likely to refuse treatment. It empowers the Guardianship Board to make an order authorizing the giving of medical treatment for a period specified in the order.

One of the 34 patients for whom a treatment order was made had that order made under section 32 of the Act. The other 33 patients had their orders made under section 45 of the *Guardianship and Administration Act 1995*.

This section allows the Guardianship Board to consent to medical treatment if the person is incapable of giving consent. This is a section that was designed for one-off medical treatment such as an operation, sterilisation, etc.

However, in the case of the 33 involuntary mental health patients for whom an order was sought, the section was used to obtain consent for the ongoing administration of pharmaceutical treatment whilst they were detained in an approved hospital.

The section does not stipulate any time frame in which the decision that the patient lacks capacity or the type of drugs administered is to be reviewed.

Mental illness is a condition where the capacity of the patient may fluctuate dependant upon their mental state at the time, their insight into their condition, whether or not they are medicated and a number of other factors that vary from time to time.

Section 45 of the Guardianship Act is designed to allow treatment of those whose lack of capacity is unlikely to change.

Further, there is nothing in the Act that invalidates or terminates an order of the Board, once made, if the patient regains capacity but refuses the treatment, and the Board has no capacity to review its own order.

A patient in this situation who has regained capacity and who refuses medication can continue to have that medication administered against their will in accordance with the order made by the Board.

In all other Australian jurisdictions the Mental Health Tribunal when reviewing an order relating to the detention of a person can approve treatment for that person if they are either incapable of giving consent or unreasonably refuse to give consent to that treatment.

The Tribunal being the body empowered to consent to treatment has a number of advantages over the current situation. Firstly it negates the need for two hearings, one relating to detention and the second to treatment, thus relieving the burden that two hearings place upon mental health professionals and the resources available to the mentally ill. Secondly, the decision would be reviewable upon application to the Tribunal if there were a change of circumstances, in the same way as other decisions of the Tribunal are reviewable upon application. Thirdly, the order would only be valid for a maximum period of six months without requiring the renewal of the order and the review of that renewal by the Tribunal, thus protecting the patient's civil rights. Fourthly, and in the view of the Tribunal most importantly, the Tribunal would not be placed in a position where it was ordering the detention of that person simply for the purpose of removing them from the community.

It is the Tribunal's view that a person should not be deprived of their liberty under the *Mental Health Act 1996* unless the purpose of the deprivation is to provide them with care and treatment.

It is interesting to note that the Tasmanian Forensic Tribunal, that is also chaired by the President of the Mental Health Tribunal, has been given the jurisdiction to both review the detention of the patient and to authorize treatment for patients on Forensic Orders.

## **GAPS IN SERVICE**

### ***Between Discharge From Hospital And Receiving Treatment In The Community - A Case Study***

X was placed on a Continuing Care Order on the 2<sup>nd</sup> July 2005. The order was due to expire on the 2<sup>nd</sup> October 2005.

X was placed on leave from the hospital on the 26th July 2005 to return to the hospital on the 14th August 2005 at 5pm.

The matter was listed for hearing on the 26<sup>th</sup> July 2005. A three-member tribunal panel sat at the Department of Psychological Medicine. X's case manager was notified of the hearing but did not attend. A Registrar attended the hearing and advised the Tribunal that X had been discharged from hospital that morning and had left the hospital.

The matter was adjourned to allow X the chance of attending and to ensure that the case manager was available to advise the Tribunal of X's management in the community.

The matter was relisted for hearing on the 23<sup>rd</sup> August 2005. The Case Manager, X and the Registrar were notified of the hearing. X's notification of the hearing was returned to the Tribunal marked 'not known at this address.'

On the day before the hearing the Tribunal received an email stating that the Case Manager would not be attending the hearing as she was on leave and that there was no-one else at X's treatment centre, who knew X, so nobody would be attending the hearing.

On the day of the hearing the team leader at the treatment centre was contacted. The team leader confirmed that nobody from the community team would be attending the hearing.

The team leader was advised that the Tribunal required evidence of the necessity for the order and that included evidence of the risk to X and others were X to be in the community without an order.

The Tribunal then received a fax. The gist of the fax was that X requires an order. X has not been seen since she was discharged from hospital nor is there any intention that X will be actively case managed or followed up unless X contacts the service and requests the same.

At 3pm that day a three-member panel again attended the Department of Psychological Medicine. The Registrar attended and gave evidence that X had been discharged on the 26<sup>th</sup> July 2005 on a leave of absence. She provided the Tribunal with a report that stated that as at the 26<sup>th</sup> July 2005 X was 'at risk of taking an overdose of medication, at risk of harm to others in response to delusional thoughts and needs ongoing monitoring and observation to ensure she takes the correct dose of medication'.

There was no evidence before the Tribunal of X's current mental state or the current need for an order.

It was pointed out by the Tribunal that it is the responsibility of Mental Health Services to provide to the Tribunal evidence, that the patient, at the time of the hearing, meets the criteria, set out in the Act, for an order.

The purpose of an order is to minimise the risk of harm to the patient and others and to decrease the risk of a deterioration of the patient's health. Whilst it would appear prima facie that were X's current mental state to be, at the time of the hearing, as it was upon her discharge from hospital, an order would be appropriate, it would appear from the Team

Leader's fax that an order would not achieve either, a minimisation of the harm to others or a minimisation, of the risk that X's mental state will decline.

In fact if X were only to be seen when contact is made with the service then no order would be necessary as such contact would be made on a voluntary basis.

The matter was again adjourned to enable the treating team to provide the Tribunal with material relating to the need for the order and the purpose that it served.

On the third occasion the matter was listed for hearing, after being threatened with the issue of a summons, the team leader attended the hearing. The Registrar also attended but there was no appearance from the patient.

The Registrar gave evidence that whilst X had settled at the time of discharge and was no longer expressing delusional thoughts X continued to lack insight and the risk of overdose and harm to others remained significant. The Registrar stated that X was currently on a leave of absence from the hospital and a condition of that leave was that there be no self-harm. X had not been seen by any person since leaving the hospital.

The Tribunal pointed out to the Registrar that X was not in fact on a leave of absence. X had been placed on a leave of absence on the 26<sup>th</sup> July 2005 until the 14<sup>th</sup> August 2005.

X did not return from leave on the 14<sup>th</sup> August 2005 and was therefore currently absent from the hospital without leave.

Section 38(2)(a) of the *Mental Health Act 1996* states that if a patient has been absent without leave for a period of more than 28 days the controlling authority can no longer authorise a police officer or an authorised officer to take the patient into protective custody.

As of the date of the hearing X had been absent without leave for 23 days. The Tribunal put to the Registrar and the team leader that if they wanted the current order to have any affect they would need to authorise X to be taken into protective custody. This would require X being located and returned to the hospital within five days. Both the Registrar and the team leader stated that they could not give the Tribunal an assurance that this course of action would be undertaken.

Whilst the Tribunal was satisfied pursuant to section 24 that X

- appears to have a mental illness, namely a schizoaffective disorder and that,
- there is, in consequence, a significant risk of harm to X as a result of self-harm and to others as a result of X acting upon delusional thoughts,

The Tribunal could not be satisfied that the detention of the person as an involuntary patient was necessary to protect the person or others.

On the one hand the Tribunal had the evidence from the Registrar that X “requires ongoing monitoring and observation to ensure that the correct dosage of medication is taken” and the team leader “that X should remain on the order as there are a lot of issues that X needs to work on, together with X’s disorganisation with medication”.

On the other there was the evidence that X’s community file showed no germane notations to this order, the last comment on file being on the 31<sup>st</sup> May 2005. X was not placed on the order until the 2<sup>nd</sup> July 2005. Further, none of the treating team was aware that X was currently absent without leave, had sighted X or was aware of where X was or X’s current mental state.

Neither the Registrar nor the team leader could assure the Tribunal that any action would be taken in pursuance of the order and the team leader’s evidence was ‘if X contacts, a member of the team would be happy to see X.’

The Tribunal determined that it is logically inconsistent to state that a person should be on a Continuing Care Order because they need constant monitoring and then to admit that no monitoring had in fact taken place and nor was it intended that the patient would be monitored in any way.

X had been absent from the hospital for 42 days without any attempt being made to locate or monitor X in any fashion. For 23 days X had been absent without leave without anybody being aware of this fact. No responsibility was taken by the treating team to ensure, as required in section 6(g) that all practicable measures are taken to prevent mental illness or to arrest or impede its progress at an early stage or section 6(j) to encourage the care and treatment of persons with mental illnesses in the community and to design and coordinate an integrated system of community support services for persons with mental illnesses who are being cared for in the community’. As a consequence the Tribunal stated that the Order was simply a piece of paper that had no impact on the care and treatment of X.

As the Act requires that the Order be necessary to protect X or others and the Tribunal had found that the Order did not protect anybody, the Order was revoked.

**This case highlights a number of systemic failings: -**

When a person is placed on a leave of absence from the hospital there is no register of when the leave expires.

A copy of the leave of absence was only forwarded to the community team a month after the leave was granted.

Neither the Doctor nor the team leader was aware of the date the leave expired.

Neither the Doctor. nor the team leader showed any intention of following up a patient who was absent without leave.

There was no clear delineation of who was responsible for a patient on a leave of absence – consequently nobody took responsibility.

There was a total lack of communication between the hospital and the community team at the time the patient was discharged from the hospital.

There was no real consideration to the conditions placed on the leave of absence and their purpose.

The conditions placed on the leave of absence were seen as giving the patient a responsibility to take certain actions but were in no way seen as placing any responsibility on mental health services to take actions.

When the allocated case manager was on leave there was no follow up of patients being seen by that case manager

There was at no time, despite urgings by the Tribunal and two adjournments of the matter, any attempt made to locate the patient.

There was by both the Doctor and the team leader no understanding of the logical absurdity of stating that the Tribunal should confirm an order because the patient needed constant monitoring and the fact that the patient had not been seen by anybody since discharge from hospital 23 days earlier.

There was no acceptance by the team leader that there had been any failing on the services part and for him it seemed sufficient that they would provide a service to the patient if they were contacted by the patient.

There was also no acceptance by the team leader that he had any role in the Tribunal process except to state via phone that he wanted the order confirmed.

### ***Between being placed on a Community Treatment Order and receiving treatment in the community***

The Tribunal has also written to the Secretary of the Department of Health regarding a further gap in service that occurs between the discharge of a patient from the Department of Psychiatric Medicine and their assessment and review in the community.

There are two issues that the Tribunal has identified as unsatisfactory in the current system.

Firstly, from the Tribunal's perspective: -

The current situation is that a patient is placed on a Community Treatment Order by the treating team prior to discharge from the Department of Psychological Medicine. Their hearing before the Tribunal is, in accordance with the Act, listed within 28 days of the

Community Treatment Order being made. Usually, the patient, at the time of hearing, has not been seen by the community team. The community team are unable therefore to comment on the need for the order. The Department of Psychological Medicine's doctors, who made the order, are not able to comment on the patient's current condition or the current need for the order. This results in a situation where the Tribunal at hearing has no evidence before it relating to whether the patient meets the criteria set out in the Act and thus must either adjourn the matter to seek this material or revoke the order.

Secondly, from the patients, their family and the community perspective, it is unacceptable that a patient who needs an order so that they can obtain appropriate treatment and support in the community has not been seen professionally for a period of 28 days because resources are not available for this to occur.

## **ONGOING EDUCATION**

Upon their appointment all members are provided with a comprehensive set of materials as part of their induction to the Tribunal. They also attend a full day induction-training program provided by the President and Registrar.

As a supplement to the materials provided at induction, members receive a members manual, quarterly newsletters, copies of written reasons for decisions that are of note, and lists of new articles of relevance to the jurisdiction.

The Tribunal has continued to add relevant educational articles to its lending library.

Whilst the President attended, and spoke at, the International Therapeutic Jurisprudence Conference in Perth, the Tribunal's budget did not allow it to offer the opportunity to any of the other members of the Tribunal to attend a relevant conference. This lack of budget for ongoing education combined with the sessional nature of Tribunal work limits the members' ability to interact with others in their field, to advance their knowledge of practice and procedure in other jurisdictions, and to further their knowledge of both mental health and the law.

## **MENTAL HEALTH TRIBUNAL - TRANSPARENCY OF PROCESSES**

Whilst the *Mental Health Act 1996* does not require the Tribunal to provide written reasons for its decision, the Tribunal has continued to do so.

It is the view of the Tribunal that the distribution of reasons for decision not only has the potential to increase the public's confidence in the Tribunal but in the whole of the mental health system. Written reasons provide the opportunity to educate all users of the Act in its appropriate use and interpretation.

Despite the educational value for all users of the system the Tribunal has received only three requests for reasons from patients this year and has issued, of its own initiative, to the mental health providers in the case, the reasons for decision in another five cases. Where decisions are made (such as the case study on page 16), which have wider ramifications for future interpretation of the Act than the case in which the decision is made, these cases are circulated without identifying features to mental health care providers and all Tribunal members.

Provision of written reasons for decisions to mental health care providers affords an opportunity to educate the providers on interpretation of the Act, the presentation of material to the Tribunal and the likely outcome of future hearings.

## **FUTURE DIRECTIONS**

In the coming twelve months the Tribunal will continue to increase the confidence of patients, mental health professionals and the public in the Mental Health Act and the Mental Health Tribunal by:

- taking an active role in training and assessing persons used by Advocacy Tasmania to represent patients in hearings before the Tribunal;
- maintaining the system of providing written statements of reasons for decisions of the Tribunal;
- monitoring and reviewing the Tribunal's hearing procedures;
- developing the skills of members in the conduct of review hearings;
- continuing the education programme for Registrars and other mental health providers to assist in their presentation of relevant material to the Tribunal;
- continuing presentations and seminars to professional bodies;
- continue to identify systemic deficiencies in the provision of mental health care in this State;
- continue to promote the Objects set out in the Mental Health Act; and
- actively participate in, and lobby to progress, the long delayed review of the Mental Health Act.

# Administration of the Mental Health Tribunal

## STAFF

At 30 June 2006, the following staff undertook the Tribunals' administration:

**Registrar:** Dale Webster

**Executive Officer:** Jane Bliss

**Advisory Officer:** Andrée Feil

The Tribunals' administrative staff are shared with the Guardianship and Administration Board and the Tasmanian Forensic Tribunal. The staffing complement is equivalent to just over two full time positions.

## **Appendix 1 – Mental Health Tribunal Members**

### **President**

#### **Debra Rigby**

Ms Rigby has a Bachelor of Laws degree and was admitted as a Barrister and Solicitor of the Supreme Court of Tasmania in 1982.

From 1984 to 1997 she was employed as Criminal Counsel for the Legal Aid Commission of Tasmania and from 1991 was Deputy Director of that organisation. From 1997 until 1999 she was a Principal Legal Officer with the Legislation, Policy and Strategic Direction Division of the Department of Justice and Industrial Relations. In 1999 she was appointed Commissioner for Criminal Injuries Compensation, a role she holds concurrently with her appointment as President of the Tribunal.

### **Deputy President**

#### **Ann Cunningham**

Ms Cunningham holds a Bachelor of Laws degree (with Hons.) and is admitted as a Barrister and Solicitor of the Supreme Court of Tasmania. Ms Cunningham was until 1999 Deputy Registrar of the Family Court of Australia. Ms Cunningham practices part-time as a legal practitioner and is a member of the Administrative Appeals Tribunal, the Resource, Management and Planning Appeals Tribunal and is a Complaints Commissioner with the University of Tasmania. Ms. Cunningham is an accredited arbitrator and mediator with the Law Society of Tasmania.

### **Approved Medical Practitioner**

#### **Martin Morrissey**

Dr. Morrissey completed his training as a psychiatrist in 1996 at Westmead and associated hospitals. He was awarded the Fellowship of Old Age Psychiatry in the same year and the Fellowship of the Royal Australian and New Zealand Institute of Psychiatry in 1997. Dr. Morrissey practiced in Northumberland, England until 2002 when he commenced a position as Consultant Old Age Psychiatrist with the Department of Health and Human Services in Tasmania.

### **Members (in alphabetical order)**

#### **Kim Barker**

Ms. Barker has extensive experience working with people with disabilities, including mental illnesses. She currently has a small private practice as a rehabilitation consultant, counselor and mediator, and is a member of the Guardianship and Administration Board. She undertakes dispute resolution as Chair of the Tasmanian Training Agreements Committee, and is a Director of the Motor Accident Insurance Board. Ms. Barker's

qualifications include a Bachelor of Arts degree (psychology), Diploma of Education and a Graduate Certificate in Counseling and Development.

### **Riitta Boevink**

Ms. Boevink graduated from the University of Sydney with a Bachelor of Social Work. Prior to her retirement from the paid full time workforce in 2002 Ms. Boevink was the Team leader at the Oldaker Street Clinic, which is part of Mental Health Services. Ms. Boevink worked in Mental Health Services in Tasmania for 19 years in various Social Work roles.

Ms. Boevink was a founding member of the Launceston branch of ARAFMI and has a long-standing interest in promoting the interests of persons with a mental illness, particularly as informed consumers.

### **Christine Brooks**

Ms. Brooks is a registered psychiatric nurse who has had extensive experience in nursing acute psychiatric patients in both England and Australia.

### **Susan Carroll**

Mrs. Carroll graduated from the University of Queensland with a Bachelor of Social Work. She has 14 years experience as a social worker and senior social worker at Royal Hospital Brisbane and Royal Women's Hospital Health Services District, Queensland.

### **Moya Cassidy**

Ms. Cassidy obtained first class honours (Sociology) as part of her studies towards a combined Bachelor of Arts and Bachelor of Laws degree. She was admitted to the Bar of the Supreme Court in August 2001. Ms Cassidy also holds a Diploma in Mental Health Nursing. She has had extensive experience in mental health working in both hospital and community settings as a Mental Health Nurse. She is presently employed as Court Liaison Officer, Forensic Mental Health Services. Ms Cassidy has a particular interest in the areas of mental health rehabilitation and mental health law.

### **Eric Cave**

The Reverend Canon Eric Cave is a Senior Anglican Chaplain and Anglican Prison Chaplain. He is an accredited Clinical Supervisor and has continual contact with psychiatric patients in his many and varied roles across a broad socio-economic range. He has been engaged as Hospital Chaplain at the Royal Hobart Hospital for the past 16 years and has previously developed a chaplaincy presence to the psychiatric area.

### **Gail Drury**

Ms. Drury holds a Diploma of commercial studies from South Berks College of Further Education. Her work experience includes several years as an Administrative Officer/Medical Records Clerk at the North West Regional Hospital, Burnie and with Mental Health Services, Spencer Clinic at Burnie. Ms. Drury is a Justice of the Peace, and also an Official Visitor under the *Mental Health Act 1996*.

### **John de Jong**

Mr. de Jong is a registered psychologist in private practice in Devonport. He holds a Bachelor of Arts degree (Psychology) from Deakin University and a Graduate Diploma Counselling Psychology from Monash University. Mr. de Jong's previous employment has included positions as a Child Welfare Officer and the Coordinator of Youth Justice with the Department of Health and Human Services. He has also worked as a clinical psychologist at Dunburn House in Burnie.

### **James (Jim) Frost**

Mr. Frost's career started in Teaching, before a long career in business in the 1960s and 70s. In 1981 a career direction change saw him appointed as a Probation and Parole Officer and from 1985 to 1996 Mr. Frost managed the Devonport Region of Community Corrections.

Mr. Frost elected to return to case management in 1996 and continued in that role until his retirement in 2004.

### **Susan (Sue) Hill**

Ms. Hill holds a Bachelor of Laws degree and was admitted as a barrister and solicitor of the Supreme Court of Tasmania in 1978. She worked in private practice from 1981 until 1993. She has lectured and tutored in Business Law at the Hobart TAFE and the University of Tasmania in Launceston. Ms. Hill was instrumental in establishing the Northern Community Legal Service in Launceston. She is a member of the Guardianship and Administration Board, the Standards Panel of the Local Government Association and the Tasmanian Library Advisory Board. Ms. Hill was also a member of the Social Security Appeals Tribunal for 15 Years.

### **Marguerite Lester**

Mrs. Lester holds a Bachelor of Applied Science (Occupational Therapy) degree and a Master in Business Administration. She is currently employed in a part time occupational therapy position working closely with general practitioners and their patients in northern Tasmania. Past experience includes employment with organizations involving people with disabilities – Aged Care Assessment Team, Vocational Rehabilitation Service, St Giles in the north of Tasmania and other Hobart based facilities. Mrs. Lester is a member of the Guardianship and Administration Board and is the allied health representative on the

Chronic Disease and Integration Taskforce for the General Practitioner Partnership Advisory Council.

**Michael (Mike) Marriott**

Mr. Marriott graduated from the University of Queensland with an M.A. in Psychology in 1982, and for the past 15 years has been in private practice as a clinical and forensic psychologist in Burnie.

**Alec More**

Mr. More graduated with BA (Hons), Melbourne University. From 1993 until recent retirement he was a consultant psychologist with Centrelink. For 8 years Mr. More was a manager with the Victorian Accident Rehabilitation Council.

**Anna Nicholson**

Ms. Nicholson graduated with BA/LLB from the University of Tasmania in 1998 and is at present a legal practitioner with Levis Stace & Cooper with whom she has been employed since October 2000. Prior to this Ms. Nicholson was a legal practitioner with the Legal Aid Commission and also with McLean, Phillips & Bartlett, Burnie.

**Dianne (Di) Reynoldson**

Ms. Reynoldson has a B. Occ. Thy. and since 1995 has been a rehabilitation consultant with Lifestyle Management Systems. Prior to this she worked briefly in the same area for Social Security.

On first coming to Tasmania Ms. Reynoldson worked primarily in Disability Services at Willow Court and the then Douglas Parker Centre. She has extensive experience working in Tasmania, Queensland and the United Kingdom.

**Frederick (Fred) Thornett**

Mr. Thornett holds a Bachelor of Arts (Psych) degree, a Diploma of Education and a Teachers certificate. He has held various positions as a lecturer. He has had experience as a trustee for mentally ill people when working with the Department of Veteran's Affairs. Mr. Thornett is also a Justice of the Peace and regularly sits as a Bench Justice in the Magistrates Court.

**Jon Visoiu**

Mr. Visiou graduated from the University of Tasmania in 1989 with BA (Psych) (Hons). As a psychologist in private practice, he also works part time at Oakrise Clinic, Launceston and Ashley Youth Detention Centre. Previous experience includes employment as a Guidance Officer / Psychologist with the Education Department from 1990-98.

**Kereth West**

Ms. West holds the degrees Bachelor of Arts with Honours and Master of Psychology and has worked as a Clinical Psychologist since 1984 in both Mental Health Services and Intellectual Disabilities Services. She currently holds the position of Clinical Psychologist with a Community Mental Health Service in Glenorchy, and is also a member of the Guardianship and Administration Board.

**Louise Whitehead**

Ms. Whitehead holds a Bachelor of Arts (Hons.) and a Master of Psychology. Now retired, she worked as a Clinical Psychologist from 1977 to 2004 in Mental Health Services and in private practice.

**Philippa (Pip) Whyte**

Ms. Whyte holds a Bachelor of Laws degree and was admitted as a Barrister and Solicitor of the Supreme Court of Tasmania in 1980. Since then she has worked as a lawyer in private practice for over 22 years. In 2002, she was appointed to the position of Conciliation Officer within the office of the Health Complaints Commissioner.

She is a trained mediator and is also a member of the Guardianship and Administration Board and the Social Security Appeals Tribunal.

**Gwynneth Williams**

Ms. Williams is a registered Psychiatric and General Nurse. She is employed in the Acute Admissions Psychiatric Ward (1E) of the Launceston General Hospital and has had 20 years experience in working with people with mental illnesses in New South Wales and Tasmania. Ms. Williams previous employment has included positions as Coordinator, Aboriginal Mental Health, Clinical Nurse Specialist, Mental Health Counsellor and Team Leader at the Mid-West Health Service, Community Mental Health Service, in Orange.

**Peter Wise**

Mr. Wise graduated with BA/LLB in 1991. He has been manager of Legal & Compliance, at the Retirement Benefits Fund Board for over six years and in that time has dealt with applications for invalidity pensions and a range of legal issues.

## Appendix 2 – MHT Statistical Summary

	<b>2001- 02</b>	<b>2002- 03</b>	<b>2003- 04</b>	<b>2004- 05</b>	<b>2005- 06</b>
No of applications received	22	18	25	27	34
No of notifications received of Continuing Care Orders	355	400	460	473	388
No of notifications received of Community Treatment Orders	19	9	6	22	117
No of orders discharged prior to hearing	231	240	231	286	261
No. of Continuing Care Orders discharged by the making of a Community Treatment Order					39
No of hearings conducted	170	177	215	210	227
No of orders confirmed	119	110	184	150	119
No of orders revoked	17	16	26	37	35
No of orders varied	19	19	20	30	49
No of orders invalid	3	2	1	2	9
Matters adjourned	11	Nil	2	18	5
Outstanding matters listed for hearing at 30 June	18	17	18	33	5
% of reviews conducted within statutory time frame	98	98	99	99	99

## Appendix Three – MHT Financial Statement 2005-06

	Budget	Actual Expend	Variation
<b>EMPLOYEE RELATED</b>			
Salaries (incl Rec/LSL)	148,363	142,998	5,365
Board Member Fees	40,488	59,391	-18,903
Other		24	-24
Work Comp Ins	300	248	52
Payroll Tax	14,118	13,780	338
FBT	5,600	2,157	3,443
Superannuation	19,940	21,200	-1,260
Training	1,500	1,666	-166
<b>Total Employee Rel</b>	<b>230,309</b>	<b>241,464</b>	<b>-11,155</b>
<b>TRAVEL AND TRANSPORT</b>			
Travel	7,200	8,910	-1,710
Vehicle leases	7,000	7,002	-2
Vehicle other	1,600	688	912
Fuel	1,800	2,615	-815
<b>Total Travel &amp; Trans</b>	<b>17,600</b>	<b>19,215</b>	<b>-1,615</b>
<b>ADVERTISING / PROMOTION</b>			
Advertising	200	383	-183
Printing	1,000	326	674
<b>Total advertising</b>	<b>1,200</b>	<b>709</b>	<b>491</b>
<b>COMMUNICATIONS</b>			
Postage	0	54	-54

Telephone	2,400	2,122	278
Other	0	0	0
<b>Total Comms</b>	<b>2,400</b>	<b>2,176</b>	<b>224</b>

#### CONSULTANCIES

Consultant (non IT)			0
<b>Total Consultancies</b>		<b>0</b>	<b>0</b>

#### ACCOMMODATION

Office Rental	30,431	24,258	6,173
Other	0	177	-177
<b>Total Accom</b>	<b>30,431</b>	<b>24,435</b>	<b>5,996</b>

#### INFORMATION TECHNOLOGY

Other Op leases	10,642	11,737	-1,095
Office equip under \$5000	500	1,064	-564
Comp hardware under \$5000	0	721	-721
Software licences	3,000	2,998	2
Other computers	0	0	0
<b>Total Info Tech</b>	<b>14,142</b>	<b>16,520</b>	<b>-2,378</b>

#### OTHER EXPENSES

Other admin		491	-491
Office requisites	3,000	3,327	-327
Equip maintenance	200	220	-20
Miscellaneous	0	1,939	-1,939
<b>Total Other Exp</b>	<b>3,200</b>	<b>5,977</b>	<b>-2,777</b>

<b>TOTAL</b>	<b>299,282</b>	<b>310,496</b>	<b>-11,214</b>
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