ANGLICARE TASMANIA

Review of the

Draft Mental Health Bill 2011

September 2011

for further information, please contact:
Dr Chris Jones
Chief Executive Officer
Anglicare Tasmania
GPO Box 1620, HOBART TAS 7001
ph: 03 6231 9602
email: c.jones@anglicare-tas.org.au

Contents

1. Executive Summary

Anglicare acknowledges the good work already undertaken by the Tasmanian Government in preparation of this Draft Mental Health Bill (2011). Based on our recognition that this is a Draft Bill 'nearing completion' (but still requiring substantial changes) and on our hope that Tasmanian parliamentarians will legislate a new Mental Health Act in the near future, Anglicare provides a comprehensive submission. This submission is based predominantly on advice provided by service users with 'lived experience' of the current Mental Health Act, as well as service providers and family members.

Anglicare recognises that the people most affected by the current and proposed Mental Health Acts are amongst the most vulnerable in the Tasmanian community – those who live with mental ill health, and especially people who experience episodes of mental illness. Our aim via this submission is to contribute to the development of a highly effective Tasmanian mental health care service system – one that ensures people's rights are safeguarded and supports the promotion of mental health.

Based on the content of the current and proposed Mental Health Acts, the emphasis of this submission is on Tasmania's mental health treatment sector, but Anglicare's response includes a system-wide focus. Therefore this document offers a summary of fundamental, specific and targeted changes – changes we believe will make a difference to the entire mental health care service system, as well as within clinical mental health treatment settings.

Many of our recommendations relate to language, and include a request that the Tasmanian Government consider using the term *mental ill health* in place of *mental illness* within this Bill. We believe this change in language will be another step in the process of working to increase understanding, and de-stigmatise mental illness in the Tasmanian community. In clinical treatment settings, such a shift in terminology will help staff to maintain a focus on supporting mental health (rather than ameliorating mental illness). We believe such a change, legislated, will help mental health treatment settings to become more focused on health promotion. These and other recommended changes will mean service providers are more like to enact recovery principles - 'hold hope' and 'convey hope' to service users – based on the expectation that people will continue their recovery. We consider this to be a critical point, and an opportunity for the Tasmanian Government to show leadership, by legislating a crucial shift in terminology relating to mental health treatment. The Draft Bill has already come a long way by moving language in the current Mental Health Act from 'detention' to 'treatment'. This submission requests that a refined Bill move from the language of 'treatment' to the language of 'mental health promotion and recovery'.

A second area of substantial change highlighted in this submission, is Anglicare's request that the Draft Bill integrate a role for social support in clinical mental health treatment. Social support is so vital to effective mental health that it should be considered a central pillar of Tasmania's mental health treatment practices, and legislated accordingly. On this basis, Anglicare requests that changes be made to the Draft Bill to increase likelihood that social support will be provided to people, including opportunities for social support within inpatient settings. These changes are worth making at this point in time, as they will help to place Tasmania's legislative framework at the leading edge of the national and state policies that seek to embed evidence-based mental health promotion and recovery-oriented practices at the centre of mental health treatment. Whilst ambitious, Anglicare believes these changes are worth pursuing, and to assist the Tasmanian Government in this process, we offer specific examples of how this might be achieved (see section 5).

Anglicare considers this to be a Draft Bill 'nearing completion', but that the Bill does not yet make full use of this once-in-a-decade opportunity to install best practice policies and principles within mental health legislation.

In the context of an under-resourced mental health treatment system, both the Tasmanian Government and the community need to be looking for alternative ways to support the mental, emotional and social health of people living with mental ill health - including via intra-sector linkages, application of recovery principles, and the strengthening of peoples' social support networks. This submission provides Anglicare's solutions to those aims, via recommended refinements to the Draft Bill.

We understand that mental health care already requires a significant fiscal outlay by the Tasmanian community, and recognise that requests embedded in this submission require resourcing. We also recognise that savings will be made by the Tasmanian community if we get mental health care 'right'. Therefore, this submission comes with a fundamental request that the Tasmanian Government prioritise adequate funding for essential services across our mental health care service system, including mental health treatment.

Summary of recommendations

Recommendation 1.
That the Bill provide a summary of key international conventions Australia is signatory to along with relevant Charters the Tasmanian Government endorses that relate directly to the safety and care of people experiencing mental ill health.

Recommendation 2.
That wherever possible, the Bill highlight aims of safety and care (for service users and service providers) in place of aims of 'controlling' a person.

Recommendation 3.
That the Bill embed language that links mental health treatment with other forms of mental health care delivered across the spectrum of mental health services (including prevention, early intervention and continuing care).

Recommendation 4.
That the Bill highlight the role treatment services play in promoting mental health, including assisting to prevent further episodes of mental illness.

Recommendation 5.
That Schedule 1 within the Draft Bill is reworked to include service delivery principles relating to a focus on: safety, mental health prevention and recovery, the importance of providing social support, the importance of providing social support or an advocate at key treatment transition points, and the importance of beginning discharge planning upon admission.

Recommendation 6.
That the Bill embed recovery principles throughout, including refocusing the language of the Bill to reflect an emphasis on mental health and an aim of maximising this (in the context of treating mental illness).

Recommendation 7.
That the Tasmanian Government examine how 'advanced directives' may be used within treatment and care plans (in both acute and community settings) as a means of both engaging people in their own recovery process, and ensuring people have the opportunity to engage in decisions relating to their own care.

Recommendation 8.
That the Bill include a provision for 'advanced directives' within patients' treatment plans to ensure they have opportunities to engage in decisions relating to their own clinical treatment, prior to illness.

Recommendation 9.
That the Bill be refined to include an additional set of key terms, that these key terms be interpreted according to language consistent with mental health promotion and mental health recovery, and that these key terms be embedded throughout the Bill.

Recommendation 10.
That the Bill be refined to require that mental health treatment settings provide opportunities for social connection for patients, that specific opportunities for patients to gain social support are provided at key treatment transition points, and at certain points, if nominated social support is not available, advocacy support is mandated.

Recommendation 11. That definitions of 'mental capacity' are refined within the Bill to centre around capacity for personal safety and judgement.

Recommendation 12. That decisions relating to 'special psychiatric treatment' are safeguarded by including a requirement that a nominated support person is notified prior to commencement of treatment, and if not available, a note made in clinical records to that effect.

Recommendation 13. That clearer maximum time limits be articulated regarding the length of time a person may be held in protective custody before they are assessed, and clearer delineation be made between those who have been assessed and those who remain unassessed in regards to protective custody.

Recommendation 14. That the Bill clearly articulate that the use of force, restraint and seclusion are for safety and will only be used as a 'last resort'.

Recommendation 15. That the right for patients to refuse treatment is articulated throughout the Bill; and 'refusal alone does not imply mental incapacity'.

Recommendation 16. That the Bill require the intended frequency of reviews be documented within assessment orders, treatment orders, and patients' treatment plans, to a maximum of three months.

Recommendation 17. That the Bill stipulate a responsibility for mental health practitioners and the Mental Health Tribunal to notify a support person at key treatment transition points, and if unavailable, a note made in clinical records to that effect.

Recommendation 18.
That the Bill require all mental health practitioners, mental health officers, Chief Psychiatrists and Official Visitors to undertake training in mental health promotion and mental health recovery principles.

Recommendation 19.
That the Bill identify that the powers of the Chief Psychiatrists relating to direct intervention include responsibilities to both patients and support people, including an expectation that they will communicate with patients' support people at key treatment transition points.

Recommendation 20.
That the Bill identify that the powers of the Chief Psychiatrists relating to independence are based on their position of assumed responsibility for supporting Tasmanians experiencing an episode of mental illness.

Recommendation 21.
That where the Bill currently refers to interim decision-making powers of one member of the Mental Health Tribunal, this be changed to two members.

Recommendation 22.
That the Bill identifies specific preferred transport options for patients (during protective custody, transfer and discharge), including a preference for non-police vehicles, and if police vehicles must be used, cars are preferred.

Recommendation 23.
That the Bill identify a requirement that approved facilities ensure patients have comprehensive discharge plans in place before discharge, including plans for accommodation, transportation and social support.

Recommendation 24.
That the Bill identify a requirement that approved facilities must report patient discharge plans and subsequent discharge processes to the Mental Health Tribunal, including occurrences when patients were discharged into homelessness.

Recommendation 25.
That statements of patient and family member rights are stated clearly within the new Bill, including the right to refuse treatment and/or request another form of treatment.

2. About Anglicare Tasmania

Anglicare Tasmania works for social justice in Tasmania through the provision of, early intervention, crisis/treatment, transitional and continuing intervention services. Anglicare is the largest state-wide community service organisation in Tasmania. It has offices in Hobart, Glenorchy, Claremont, Sorell, Launceston, St Helens, Devonport and Burnie. In addition to delivering a suite of mental health services, Anglicare Tasmania provides a range of services in the areas of disability and aged care, emergency relief, accommodation and homelessness services, counselling, employment, acquired injury support services, alcohol and other drug services, parenting support programs, and outreach services to rural areas.

Anglicare's mental health services

Anglicare has a range of services to support people who have mental illness and their family and friends across their spectrum of needs, including:

- **The Personal Helpers and Mentors program** - for people recovering from severe, long-term mental illness.
- **The Recovery program** - provides one-on-one support for people with a diagnosed mental illness to maintain independent living in the community and recovery.
- **Pathways** (Launceston) - a structured social, recreational, vocational and living skills program for adults with mental illness.
- **Club Haven** (Devonport) - a consumer led program providing social, recreational and peer support for people recovering from mental illness.
- **Our Time** (Respite Program) – supports family and friends who support a loved one with mental illness to arrange planned 'breaks'.
- **Taz Kids Clubs** – support young people who have a parent with a mental illness by providing a range of fun, educational and peer support activities.
- **Residential Rehabilitation and Recovery Services** - at Curraghmore (Devonport) and Rocherlea (Launceston). Rocherlea includes short term sub acute care through a step up/step down program in partnership with SMHS).
- **TAMOSCH Community Housing program** (Devonport) - supports people recovering from mental illness to live independently in the community.
- **Family Mental Health and Support Service** - offers information and assistance to support the family and friends of people who have a mental illness.

In 2010/2011 Anglicare's mental health services supported over 300 individuals with diagnosed or diagnosable mental illness, and over 400 families and significant support people (friends). In addition to these, Anglicare programs provide a range of mental health education throughout the community.

3. Introduction

Anglicare wishes to acknowledge the constructive efforts made in the development of this Draft Bill to improve mental health treatment and care in Tasmania. Clearly, the Draft Bill is a move towards bringing Tasmania's mental health care system up to contemporary standards in the area of clinical and forensic mental health treatment.

We consider the people most affected by the current Mental Health Act and proposed Bill are amongst the most vulnerable in the Tasmanian community – those who live with mental ill health, and particularly, people who experience episodes of mental illness. Our aim via this submission therefore, is to contribute to the development of an effective Tasmanian mental health care service system – one that ensures people's rights are safeguarded and supports the promotion of mental health.

We are pleased to see that some past recommendations made within previous consultation processes have been taken into account in this version of the Draft Bill. Within previous submissions, Anglicare has focused on a need to strengthen rights and safeguards - to protect mental health consumers from human rights violations. We maintain our previous position: that to curtail rights and freedoms of Tasmanians living with mental ill health must go hand-in-hand with stringent safeguarding. Our hope for the current consultation process is that it will draw out additional refinements from service users, as well as from service providers and peak bodies.

A key point of difference in our current submission, is that we have focused our attention on 'getting the fundamentals right'. We believe that setting a strong philosophical framework, based on existing policy directives and best practice principles, is a critical step in the establishment of a highly effective Act. We have outlined 24 specific recommendations towards that aim.

It should be noted that Anglicare's submission is based predominantly on advice provided by service users with 'lived experience' of the current Mental Health Act, as well as service providers and family members. Within tight timelines we have consulted our services, and consulted with people who live within the constraints and merits of the current Act on a daily basis. Whilst many people commented on the essential support mental health services provide and the individual goodwill of some mental health practitioners, much feedback related to how difficult it was to access mental health care, how demoralising mental health treatment settings were, how dismissive or disrespectful some mental health practitioners were – and what a difference improvements in these areas would make to their mental health recovery. This advice has lead to our recommendations.

Anglicare's response is based on the assumption that a refined version of this Bill will be presented to the Tasmanian Parliament in late 2011. For this reason, we have made every effort to attend to each interpretation, provision and directive within the Bill, and have summarised our recommendations as fundamentals, specifics and targeted recommendations. If the Tasmanian Government is to meet one recommendation we make, it is that it will seek to get the fundamentals right. This submission is based on that ambitious aim.

4. Fundamentals – and supporting evidence

4.1 Human health rights

The *Universal Declaration of Human Rights, Article 3* states 'Everyone has the right to life, liberty and security of person. Article 5 states 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. Article 7 states 'All are equal before the law and are entitled without any discrimination in violation of this Declaration and against any incitement to such discrimination'. Article 12 states 'No one shall be subjected to arbitrary interference with his privacy, family, home or correspondence, nor to attacks upon his honour and reputation. Article 13.1 states 'Everyone has the right to freedom of movement and residence within the borders of each State'. Article 25 states 'Everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control' (United Nations 1948). Anglicare considers these fundamental rights should be included within a preamble or added Schedule within the proposed Bill, in order to ensure human rights are articulated as a baseline for the proposed Act.

The *Tasmanian Charter of Health Rights and Responsibilities* outlines the rights and responsibilities of health service users and providers, including services provided 'at a hospital, health institution or nursing home' and including 'medical, dental, pharmaceutical, mental health, community health, environmental health or specialise health service or a service related to such a service', and 'services provided in association with the use of premises for the care, treatment or accommodation of persons who are aged or have a physical disability or mental dysfunction' (Department of Health and Human Services 2006). In addition, the *Australian Charter of Healthcare Rights* (Australian Commission on Safety and Quality in Health Care 2008) sets out a clear picture of rights and responsibilities to ensure safety within mental health care settings. If the Tasmanian Government endorses the rights and responsibilities outlined within Tasmanian and Australian health-related Charters, we request that mention be made of those rights and responsibilities within the Bill (and that renewed consideration be given by the Tasmanian Government to legislating key Charters).

In line with these recommendations we request that the Draft Bill reflect a focus on ensuring personal safety and that within specific provisions, 'safety' be the emphasis (rather than a need to 'control' a person's actions). It is acknowledged that the current Draft Bill goes some way towards this aim, but that interpretations and provisions relating to physical restraint, mechanical restraint, chemical restraint and seclusion require further refinement in order to reflect this aim.

Recommendation 1.
That the Bill provide a summary of key international conventions Australian is signatory to, along with relevant Charters the Tasmanian Government endorses that relate directly to the safety and care of people experiencing mental ill health.

Recommendation 2.
That wherever possible, the Bill highlight aims of safety and care (for service users and service providers) in place of aims of 'controlling' a person.

4.2 Mental health promotion

The Council of Australian Governments (2006) developed a *National Action Plan on Mental Health* that aims 'to improve mental health and facilitate recovery from illness through a greater focus on promotion, prevention and early intervention'. A National Health Policy endorsed by Australian Health Ministers in 2008 stated a vision for a mental health system that: 'prevents and detects mental illness early and ensures that all Australians with a mental illness can access effective and appropriate treatment and community support to enable them to participate fully in their community' (cited in the *Fourth National Mental Health Plan, 2009-2014).*

The *Fourth National Mental Health Plan* provides a list of principles underlying the Plan, including:

> *'Respect for the rights and needs of consumers, carers and families; Services delivered with a commitment to a recovery approach; Social Inclusion; Recognition of social, cultural and geographic diversity and experience; Recognition that the focus of care may be different across the life span; Services delivered to support continuity and coordination of care, Service equity across areas, communities and age groups; and Consideration of he spectrum of mental health, mental health problems and mental illness'* (Department of Health and Aging 2009 p.14).

These priorities encourage an integration of mental health services across the spectrum of care (including treatment), and embedding mental health promotion strategies across the entire mental health care service system (see Figure 1.)

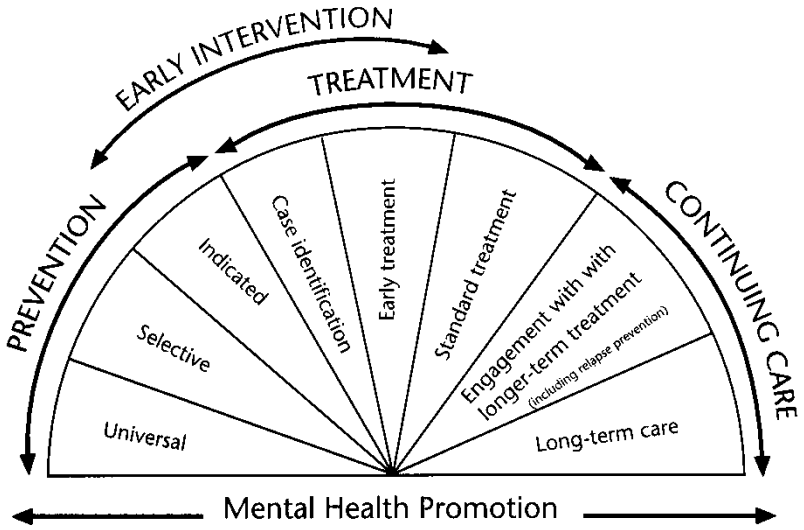

Figure 1. Spectrum of Interventions for Mental Health Promotion

(Mrazek & Haggerty 1994)

From this basis, we request the Bill acknowledge that clinical in-patient treatment is one mechanism within an holistic system of mental health care (that also includes prevention, early intervention and continuing care), and that links with these other forms of mental health care be made explicit throughout. To embed such links within legislation will be to encourage those links in a practical way. The Draft Bill does not yet make those links explicit, nor does it articulate a role for mental health promotion within treatment service settings (i.e. articulate the role treatment services have in assisting to prevent further episodes of mental ill health - in addition to 'treating' mental illness). Anglicare recognises this step may be considered merely a gesture, however we assert that this step of embedding a service linkage perspective within legislation will assist with the essential task of establishing seamless support and intra-sector collaboration within our mental health care service system. Examples of how this might be achieved are included in section 6.

Recommendation 3.

That the Bill embeds language that links mental health treatment with other forms of mental health care delivered across the spectrum of mental health services (including prevention, early intervention and continuing care).

Recommendation 4.

That the Bill highlights the role treatment services play in promoting mental health, including assisting to prevent further episodes of mental illness.

Recommendation 5.
That Schedule 1 within the Draft Bill is reworked to include service delivery principles relating to a focus on: safety, mental health prevention and recovery, the importance of providing social support, the importance of providing social support or an advocate at key treatment transition points, and the importance of beginning discharge planning upon admission.

4.3 Mental health recovery

A vision for Australia stated within the National Health Policy (2008), includes a mental health system that: 'enables recovery' (cited in the *Fourth National Mental Health Plan, 2009-2014).* Based on research and practice-based evidence, the *Tasmanian Mental Health Services Strategic Plan (2006-2011)* outlined an intended emphasis on mental health Recovery:

> *'Recovery has been described in many ways as a process, an outlook, a vision, a guiding principle. Instead of focusing on the symptomatotology and treatment of illness, a recovery approach aims to support an individual in their own personal development, building self esteem, identifying and finding a meaningful role in society to their highest possible level'*
>
> *'A recovery model provides holistic treatment and care within an active and assertive partnership between the consumer, carer and the necessary supports agencies, delivering goal-oriented and assertive care and treatment'*
>
> *'Recovery-oriented services are sensitive to the needs of consumers, their families and friends, and value independence and self-determination, It focuses on potential and strengths not deficits. It holds that every consumer has a right to the same pleasures, passions and pursuits of happiness that we have'* (Department of Health and Human Services 2006, p.9).

Anglicare requests that the Tasmanian Government work to embed recovery principles throughout the mental health service system, including in mental health treatment via this Act. This step requires embedding of this Draft Bill with a philosophy that focuses on respect, hope, self determination, and mental health (rather than just mental illness). We recognise that this step requires a considerable re-work of the existing language of the Draft Bill, as well as inclusion of specific provisions to ensure that people experiencing mental ill health (including episodes of mental illness) have access to social support and opportunities for meaningful activity. Embedding recovery principles also means guiding mental health practitioners to treat patients with respect, and as though they are at least 'partially well' at all times. From a recovery perspective, the Bill will require that all people are to be viewed by mental health practitioners as carrying some degree of mental wellness - including a degree of mental

capacity (even a person experiencing a very severe and prolonged episode of mental illness). Embedding recovery principles (and a focus on wellness) in the Bill will not change the nature of most provisions within the Bill, but will have significant implications for various specific provisions (outlined in the next section). To assist this process, we offer a detailed example of the kind of overhaul of language we are requesting, with a view to embedding recovery principles throughout the Bill. Section 6 offers examples for making this step achievable - without the loss of any safeguards or existing safety measures within the Draft Bill.

Recommendation 6.
That the Bill embed recovery principles throughout, including refocusing the language of the Bill to reflect an emphasis on mental health and an aim of maximising this (in the context of treating mental illness).

Recommendation 7.
That the Tasmanian Government examine how 'advanced directives' may be used within treatment and care plans (in both acute and community settings) as a means of both engaging people in their own recovery process, and ensuring people have the opportunity to engage in decisions relating to their own care.

Recommendation 8.
That the Bill include a place for the provision of 'advanced directives' within patient's treatment plans to ensure they have opportunities to engage in decision relating to their own clinical treatment, prior to illness.

This section has highlighted missed opportunities to date – Anglicare believes the Bill does not yet make full use of this once-in-a-decade opportunity to install best practice policies and principles within mental health legislation. We believe the work of embedding recognition that mental health treatment is part of a spectrum of care; that treatment services have a role to play in mental health promotion (including prevention); and that recovery principles have a place in clinical settings will strengthen our mental health service system. Service users report that the acute treatment area of our mental health system is under extreme pressure and is lagging behind other quarters in these regards.

We note that like the current Mental Health Act, the Draft Bill focuses on clinical mental health treatment. Whilst we request a number of fundamental changes to the Draft Bill, we are not requesting a change in the basic scope of the intended Act. We request that the Tasmanian Government 'add value' to the current Draft Bill.

Our proposed amendments will ensure that in addition to providing clinical treatment and safety (which treatment services already do well, under extreme pressure), mental health treatment settings will take up their role in the equally important task of promoting people's mental health - including helping to prevent further episodes of mental ill health for patients currently in their care. These legislated steps will assist to facilitate a seamless integration of mental health promoting practices across Tasmania's mental health care service system. The following section includes specific recommendations for how this ambitious task might be achieved.

5. Specifics – how to achieve the fundamentals

Anglicare recognises that the Tasmanian Government wishes to bring this Bill before Parliament in the near future. It is acknowledged that the Draft Bill is mostly an improvement on the current Act, and as such, already contains many important and valuable concepts, definitions, procedures, inclusions and exclusions.

Given the importance of this Bill for those who are considered amongst the most vulnerable members of the Tasmanian community - people living with mental ill health (and particularly those who experience episodic mental illness), and given the imminent tabling of this Bill, Anglicare offers more feedback than in previous submissions relating to this Bill. We have not undertaken this degree of rigorous review lightly – it is testament to our view that this Bill is critical to the health and welfare of some of Tasmania's most vulnerable people, and our hope that an improved Mental Health Act will be legislated in the near future - and from a spirit of hoping to help make that happen efficiently.

This section provides recommendations for the Draft Bill in relation to language and social support. Rather than naming the areas of the Draft Bill we already value and see merit in, this section focuses on constructive feedback. The feedback is provided in a spirit of aiming to contribute to refinements that will lead to a better Act. Anglicare's feedback includes 'requested', 'recommended' and 'suggested' changes, according to our sense of their importance - both for the Bill, and for the Tasmanian community. This section focuses on recommendations relating to definitions and interpretations. See Section 6. for targeted recommendations addressing additional areas.

5.1 Language

Anglicare recognises that language has a very powerful influence over understanding, interpretation and subsequent application of legislated Acts. For this reason (as already demonstrated in section 4) our review sought to identify ways in which the language of the current Draft Bill might move from moral judgements and/or aims of social control to an emphasis on safety and care. In these regards, the Draft Bill is a significant improvement on the current Act. We acknowledge that the Draft Bill has already made vast improvements to the current Act by moving the language of the Act from 'detention' towards 'treatment'. This submission recommends that the Tasmanian Government take the current Draft Bill from 'treatment' towards 'mental health promotion and recovery', and offers suggestions for how that might be done.

Based on feedback from service users, staff and family members, mental health treatment that focuses only on people's deficits (from a pathology perspective) misses opportunities for attending to people's wellness (a mental health perspective), including opportunities for mental

health promotion. Hence, our review sought to identify ways in which the Draft Bill currently reflects a 'deficit' approach to mental illness (rather than a 'mental health' approach to recovery); we looked for opportunities to shift language in the direction of mental health promotion and recovery.

It is our understanding that this change will help to establish Tasmania as a leader in mental health service delivery, based on strong policy and research evidence. By embedding mental health promotion and recovery principles within mental health treatment legislation, we will be setting the Tasmanian mental health care service system up for a 'healthier' future, based on a supportive legal framework. Section 6 offers more information for achieving this aim.

Our predominant recommendation relating to language is a request that the Tasmanian Government consider using the term *mental ill health* in place of *mental illness* within this Bill - except for when mental illness refers to a specific episode of mental ill health. We believe this change in language will assist to build understanding, and de-stigmatise experiences of mental ill health in the Tasmanian community.

Mental illness is currently defined within the Draft Bill as occurring 'temporarily, repeatedly, or continually'. We acknowledge that some people require acute care more than once, and some require many admissions to inpatient settings. However even the most chronic 'continual' experiences of mental illness are punctuated with wellness. The reality is that we all have periods of relative mental ill health, and that the vast majority of people with a diagnosed mental illness are mentally well (rather than mentally unwell) for the majority of their lives. The new Act needs to reflect these realities. Even in the midst of an episode of mental illness, a person carries degrees of mental wellness. Such a language change will assist service providers to 'hold hope' and 'convey hope' to service users – based on the expectation that people will continue in their recovery. We consider this to be a critical correction to the Draft Bill, because the act of holding hope and aim of maximising wellness are foundational for mental health recovery.

Recommendation 9.
That the Bill be refined to include an additional set of key terms, that these key terms be interpreted according to language consistent with mental health promotion and mental health recovery, and that these key terms be embedded throughout the Bill.

Specifically, **Part1.Div2.4(1)(p24) -** We request that the definition of 'mental illness' refer explicitly to an 'episode' of mental ill health (temporary or repeated - but not continual), and that throughout this document, mental illness is conveyed as a brief and temporary 'episode'. This change represents a substantial shift in philosophy, language and definitions - both for

this Bill, and for mental health treatment in Tasmania. This change is in line with best practices, based on recovery principles. The change in interpretation will greatly assist the Tasmanian community to move towards greater acceptance of mental ill health and mental illness, and help to ameliorate stigmatisation in our context, including within treatment services.

Further, under the definition of mental illness, a list is provided for when a person is *not* to be taken as having a mental illness. **Part1.Div2.4(2)(p24) -** We request that an additional point is added: (a) 'past experiences of mental illness'. We believe this point is necessary, given the risk that a person may be presumed to be experiencing an episode of mental illness *only* if they have experienced past mental illness (before assessment). [Part1.Div2.4(2)g(p25) - In addition, in order to remove overtones of moral judgement from the Bill, we request replacement of 'immoral conduct' with 'unsafe or illegal conduct'].

Part1.Div1.3 (p17-18) - We request inclusion of the following terms (in alphabetical order):

Add: "Mental health" – we request that the notion of mental health be embedded throughout the Bill, to ensure the mental illness is placed in the broader context and aims of mental health promotion.

Add: "Mental health care" – We suggest adding this term throughout the entire Bill, with an interpretation such as 'means the full spectrum of clinical and community-based support for people living with mental ill health, including prevention, early intervention, treatment and continuing care'

Add: "Mental health promotion" - we request that the philosophy and language of mental health promotion be embedded throughout the Bill (to encourage mental health treatment settings, staff and practices align with best practice in 'mental health promotion').

Add: "Mental health prevention" – in line with Federal and State mental health policies, we request that aims of mental health prevention be embedded throughout the Bill.

Add: "Mental health early intervention" - in line with Federal and State mental health policies, we request that aims of mental health prevention be embedded throughout the Bill.

Add: "Mental health continuing care" - in line with Federal and State mental health policies, we request that aims of mental health continuing care (or similar terminology) be embedded throughout the Bill.

Add: "Mental health recovery" - in line with Federal and State mental health policies, we request that the principles of mental health recovery be embedded throughout the Bill.

Add: "Mental ill health" – we request that consideration be given to a use of the term 'mental ill health' rather than 'mental illness' throughout this Bill, with the exception of references to 'an episode of mental illness'.

In line with language that conveys the role mental health treatment services play in the mental health care system, and in order to highlight the role mental health treatment has in promoting mental health (including preventing further episodes of mental ill-health), we recommend the following changes: **Part1.Div2.4.6(1) (p26) Meaning of "treatment" -**

(a) We suggest a change from: *'prevent or remedy mental illness'* to: 'treat or remedy mental illness, and/or prevent further symptoms of mental ill health'.

(b) We suggest a change from *'manage and alleviate where possible, the ill effects of mental illness'* to: 'manage and alleviate where possible, the symptoms of mental illness'. This returns the focus of the treatment to the person receiving treatment, rather than broader 'ill effects'.

Add: We would like to see acknowledgment that mental health treatment sits within the broad arena of mental health care, for example: '(3) It is recognised that clinical mental health treatment forms an integral part of Tasmania's mental health care system, including services providing prevention, early intervention, and continuing care services in the Tasmanian context'.

In line with the above, and in order to acknowledge the limited scope of this Act. We suggest the following changes: **Part1.Div3.13 (p33) Objects of Act -** We would like to see a refinement in the stated 'Objects of the Act', to recognise the limited scope and content of the intended Act in relation to broader mental health care, by identifying that in its current state, the Act relates to predominantly medical treatment and clinical settings, at times of mental ill health and mental illness (not all mental health treatment settings, nor all mental health care settings).

(a) - currently reads: *'to provide for the assessment, treatment, and care of persons with mental illnessess'*. We suggest changing to: 'to provide for the clinical assessment, medical treatment, and care of persons experiencing an episode of mental illness'.

(b) - currently reads: *'to provide for appropriate oversight and safeguards in relation to such assessment, treatment and care'*. We suggest changing to: 'to provide for appropriate oversight, safeguards and *mental health promotion* in relation to such *clinical* assessment, *medical* treatment and care'.

(d) - currently reads: *'to provide for such assessment, treatment and care to be given in the least restrictive setting consistent with clinical need, legal and judicial constraints, public safety and patient health, safety and welfare'*. We suggest changing to: 'to provide for such assessment, treatment and care based on mental health promotion and recovery principles, consistent with personal safety of both patients and staff, clinical need, legal and judicial constraints, public safety, and in the least restrictive setting.

(e) - currently reads: *'to promote voluntary over involuntary assessment and treatment and the making of free and informed assessment and treatment choices'*. We suggest changing to: 'to promote mental health and recovery via support for voluntary over involuntary assessment and treatment, and the facilitation of informed consent in relation to assessment and treatment choices'.

Part2.Div3.28 (p48) Matters in Common - Clinical guidelines and standing orders -

(1) – currently reads: 'Clinical guidelines and standing orders' - (a) 'are to be written in plain language with a minimum of technical and professional jargon'. Because of our hope that the Tasmanian mental health care system will follow policy directives to embed and apply mental health promotion and recovery principles at every level of service delivery, we request that the following provision is added: 'are to be based on best practice principles, including mental health promotion and mental health recovery principles. These principles recognise that mental health treatment can work against the mental health of a person if not delivered in respectful health-promoting ways'.

5.2 Social connection and support

A wealth of anecdotal, theoretical and empirical evidence supports the reality that 'social connection' is supportive of mental health (for example, see VicHealth 2011). Social connection includes many aspects of social life, including social inclusion, social participation, social networks, social engagement, and social support. Alongside freedom from poverty, discrimination and violence and opportunities for meaningful activity and sense of belonging, social connection is considered a foundational pillar of mental health promotion. Social support helps to keep us mentally well – friends, family and neighbours can help to prevent us from slipping into ill health in many ways, daily. If we are experiencing the early signs and symptoms of mental ill health (for example, increasing stress, and tiredness), yet we are connected with someone, we can be assisted to quickly return to mental health - people can assist us by intervening early (before a full blown episode of mental illness). Social supports are also critical for helping us return to health after we've been unwell. In addition to service providers, friends, family and neighbours help us return to and maximise our mental health.

Social support is also critical in the midst of a mental health crisis – our need for social support is heightened when we are at our most vulnerable. The benefits of social connection are widely recognised as a key ingredient in mental health promotion, including health promotion in clinical settings - yet anecdotally, treatment services rarely apply this evidence base. In general, social connection is not strongly nurtured within inpatient clinical mental health treatment settings. The Draft Bill does not yet embed social support as a key ingredient in mental health treatment. Anglicare believes that the inclusion of social support – and mandated advocacy at key transition points – is a vital ingredient in effective mental health

treatment, especially in a clinical setting. We suggest a raft of changes be made to the Draft Bill in line with this requirement – with acknowledged ramifications for the development of clinical guidelines.

It is our belief that social support is so vital to effective mental health treatment, that these changes are worth making at this point in time – such changes will help to place Tasmania's legislative framework at the leading edge of national and state policies that seek to embed evidence-based mental health promotion and recovery practices at the centre of mental health treatment - via mandated requirements relating to the provision of social support, including advocacy. Section 6 extends on the kinds of changes we seek in this regard – it is acknowledged that these changes will require a commitment by the Tasmanian Government to fund more Mental Health advocate positions in Tasmania – which will be a small amount of money well spent, for no doubt highly cost-effective economic and social benefit.

It should be noted that we wish to see a clear differentiation made between guardian, social support and advocate. Whilst an interpretation of guardian and advocate are based on existing legislation, we request that the definition of 'social support' be refined within this Bill. From our perspective, a 'social support' may include a guardian and advocate, and may also include a chosen: partner, family member, friend, peer supporter, support worker, or volunteer advocate. The important points are that: a) social support is chosen by the person experiencing mental ill health, and that b) a 'nominated support person' can be updated frequently (for example, with each new admission to an inpatient setting). In our vision of best practice mental health treatment, frequent communication will occur between a patient, mental health practitioners, and the patient's nominated support person – at the discretion of the patient first, and medical practitioner second. Our hope is that in the future, much more use of social supports will be made in clinical mental health settings, as already occurs in many community settings. An example of this might include the development of formalised 'peer supporter' networks within community settings. Of course informal peer networks already play an important role in prevention and early intervention in community settings, however from our knowledge, social supports (including 'peer supporters') are yet to be recognised as an essential ingredient in mental health treatment, and yet to be considered as a primary and important element in the interface between community and clinical mental health settings.

We request that a 'nominated social support person' be documented within a person's clinical records, and that opportunities to update the name of this person be offered at set transition points (along with updated contact details for that nominated support person), that a nominated support person is notified at key treatment transition pints, and that in addition, to guardian and advocate, the nominated support person may include: partner, family member, friend, peer supporter, support worker, or volunteer advocate.

Recommendation 10.

That the Bill be refined to require that mental health treatment settings provide opportunities for social connection for patients, that specific opportunities for patients to gain social support are provided at key treatment transition points, and at certain points, if nominated social support is not available, advocacy support is mandated.

Specifically, **Part1.Div2.3 (p14-23) Interpretation** - We request refinement or inclusion of the following terms:

Add: "Advocate" – along with a definition that describes the times an advocate will be offered or mandated. We suggest there are certain times in people's mental health treatment where if they do not have a support person present they should be offered the presence of an advocate, funded by the Tasmanian Government. To enable this level of support will require doubling the number of paid advocate positions in Tasmania. Anglicare sees this as a critical step for supporting people at their most vulnerable times, which will work to protect mental health (and therefore help to prevent further mental illness).

Add: "Peer supporter" – we suggest embedding this term throughout the entire Bill, with an interpretation such as 'means a pre-arranged support person with personal experience of the mental health treatment system as a service user'. The addition of this term will assist staff in both acute and community settings to respect the special expertise and support service users offer. The establishment of peer supporter networks may assist to take pressure of mental health treatment services – by giving people 'someone to talk to' in times of crisis (the crisis helpline was described as 'good' for some but 'not adequate' for many service users consulted in this review).

"Representative" (d) currently reads *'any other person nominated by the patient to represent his or her interests'*. We suggest adding: 'includes but is not limited to guardian, partner, family member, friend, peer supporter, support worker, volunteer, advocate or legal representative working explicitly in support of the person experiencing an episode of mental illness'.

"Support person" – currently reads: *'of a patient or prospective patient, means a person who provides the patient with ongoing care or support'*. We suggest changing to: 'includes but is not limited to guardian, partner, family member, friend, peer supporter, support worker or volunteer working explicitly in support of the person experiencing an episode of mental illness'.

"Representative" (d) currently reads *'any other person nominated by the patient to represent his or her interests'*. We suggest adding: 'includes but is not limited to guardian, partner, family member, friend, peer supporter, support worker or volunteer working explicitly in representing the person experiencing an episode of

mental illness'. In certain treatment transition points, if a person does not have the company of a nominated support person, they should be provided with an advocate to represent them

Further, **Part1.Div2.7(p27) Meaning of "informed consent" to assessment or treatment** -

(1) (c) We request adding 'not by coercion, including threats'.

(2) (a) Currently reads: *'the treating medical practitioner and the person have discussed the treatment'*. We request a change to become: 'the treating medical practitioner has listened to the needs of the person, and they have discussed the treatment options, including information about possible alternatives to the recommended treatment, and the positive and negative impacts of each option'. We believe this change will lead to stronger informed content than having the provision of that information given 'following initial discussions' (c i and ii).

Add: We believe it is important to add a requirement that a person is given the opportunity to discuss the implications of their treatment with a support person, therefore request that the following is added: (5) The person has been offered the opportunity to speak with a support person, and has either declined or taken up that opportunity, based on mental capacity to see both the advantages and disadvantages of gaining that support'.

In line with the provision of social support at key treatment transition points, we recommend the following changes within **Part4.Div1-Div 2 (p74-84) Involuntary patients -**

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

(1) –currently reads: *'An approved medical practitioner who affirms an assessment order is to- (a) give notice to that effect to – (i) the patient'*. We request the following safeguard is added:

Add: (ii) 'a nominated support person for the patient. If a nominated support person is unavailable, this must be documented within the patient's clinical record'.

52. Discharge of assessment order by medical practitioner or Tribunal:

(4) –currently reads: *'A medical practitioner who discharges an assessment order is to- (a) give a copy of the discharge paper to – (i) the patient'*. As above, we request the following safeguard is added:

Add: (ii) 'a nominated support person for the patient. If a nominated support person is unavailable, this must be documented within the patient's clinical record'.

53. Discharge of assessment order by change in patient status:

(2) –currently reads: *'If an assessment order is automatically discharged, the treating medical practitioner is to- (b) give a copy of the discharge paper to – (i) the patient'*. As above, we request the following safeguard is added:

Add: (ii) 'a nominated support person for the patient. If a nominated support person is unavailable, this must be documented within the patient's clinical record'.

56. Application for treatment order:

(3) – currently reads: *'The application is to be in accordance with section 204 and be accompanied by-'*. (e) *'a statement by the applicant or another approved medical practitioner regarding the state of the patient's mental health and the patient's ability to attend and participate in a hearing in the matter'*. To this provision, we wish to add the following safeguard:

Add: (f) 'the name and contact details of a nominated support person for the patient and the support person's availability to attend a hearing in the matter, in support of the patient. If a nominated support person is unavailable, this must be documented within the application for a treatment order, and a request for official advocacy support be attained to attend a hearing in the matter'.

(4) –currently reads: *'The approved medical practitioner who makes the application is to- (a) give a copy of the application to the patient (together with a statement of rights in an MHT approved form)*. As above, we request the following safeguard is added:

Add: (b) 'give a copy of the application to a nominated support person for the patient. If a nominated support person is unavailable, this must be documented within the patient's clinical record'.

58. Determination of application for treatment order:

We believe an attempt should be made by a medical practitioner and/or the Tribunal, to gain the support of a nominated support person for the patient, in the process of determining an application for a treatment order.

(1) – currently reads: *'The Tribunal may make a treatment order in respect of a patient if, and only if, it is satisfied that-'*. We request an extra provision is included:

Add: (e) 'a nominated support person for the patient has been contacted, and the treatment order has been discussed with them. If a nominated support person is unavailable, this must be documented within the patient's clinical record'.

60. Form and content of treatment order:

(1) – currently reads: *'For the purpose of (?), a treatment order is taken to be correctly completed if it-'*. We request an extra provision is included:

Add: (d) 'identifies a nominated support person for the patient, along with contact details for that person. If a nominated support person is unavailable, this must be documented within the patient's clinical record and in the treatment order'.

Changing the language, and including provisions for 'social support' as often as possible within this Bill will help to maximise health-promoting opportunities in mental health treatment. The next section provides details refinements Anglicare believes are required within the Draft Bill in relation to Rights and Safety, Training, Chief Psychiatrists, Mental Health Tribunal, Transport, Discharge, and Rights to refuse treatment.

6. Targeted recommendations

6.1 Rights and safety

6.1.1 Definition of mental capacity

Anglicare recommends that definitions of mental capacity emphasise safety and judgement, and that clinical assessments focus on these questions. For this reason, within we request the addition and refinement of the following term in **Part1.Div2.3 (p17)** -

Add: "Mental capacity" – 'a person is assessed to understand risk and safety in relation to self and others, and has the capacity to make appropriate decisions to ensure the safety of self and others'. (Note: from our perspective, clinical guidelines also need to reflect this emphasis).

Recommendation 11. That definitions of 'mental capacity' are refined within the Bill to centre around capacity for personal safety and judgement.

6.1.2 Special psychiatric treatment

Anglicare is concerned that adequate safeguards are not in place for the case of special psychiatric treatment. **Part1.Div3.15 (p35) State treatment policy** -

(1) (c) If 'special psychiatric treatment' requires the approval of the Mental Health Tribunal, we question why a provision needs to be made for a voluntary patient to be given 'special psychiatric treatment'. If a patient has mental capacity, and approves of a specific treatment on the grounds of informed consent, the Tribunal cannot overrule a patient's decision. This provision is not considered a safeguard for voluntary mental health patients, and risks becoming a loophole that either permits the Tribunal to a) overrule a medical practitioners decision, or b) overrule a patient's decision. If the former is the case, and required, then we are content with the provision; if the latter is the case, we have concerns about a lack of safeguarding of voluntary patients' right to choose their own treatment.

(2) (c) We believe that 'special psychiatric treatment' for an involuntary patient must require the consent of at least one support person. For this reason, we request an addition to this provision: '(i) the special psychiatric treatment is consented to by at least one support person nominated by the involuntary patient. If a support person has not been nominated, or if the nominated person is unavailable, this must be documented within the patient's clinical record, and the Tribunal authorisation stands alone'.

(3) (c) The same applies for forensic patients, therefore we recommend the following addition: '(i) the special psychiatric treatment is consented to by at least one support person nominated by the involuntary forensic patient. If a support person has not been nominated, or if the nominated person is unavailable, this must be

documented within the patient's clinical record, and the Tribunal authorisation stands alone'.

Recommendation 12. That decisions relating to 'special psychiatric treatment' are safeguarded by including a requirement that a nominated support person is notified prior to commencement of treatment, and if not available, a note made in clinical records to that effect.

6.1.3 Protective custody

Anglicare suggests stronger safeguards need to be in place regarding protective custody.

Part3.33-34 (p60-61):

33. Power to take person into protective custody:

Anglicare believes a limit needs to be set on the time a person can remain in protective custody based on apparent (but not assessed) mental illness. Our suggestion is a maximum of 2 hours is permitted, but understand there may be justifications for a longer timeframe. Whatever timeframe is deemed suitable, the important point is that a maximum timeframe be included within this provision. (Note: by 'maximum timeframe' we mean an estimate of a time that represents both 'as soon as possible' and 'generally achievable'), for example:

(1) – currently reads: *'An MHO or police officer may take a person into protective custody if the MHO or police officer reasonably believes that-'.* We request this be changed to: 'An MHO or police officer may take a person into protective custody up to but not exceeding 2 hours if the MHO or police officer reasonably believes that-'. (Or the decided "maximum timeframe").

(1) (a) – currently reads: '- *the person has or might have a mental illness'*. We do not see the need for inclusion of 'might have', therefore request this be changed to: 'the person *has* a mental illness'.

(1) (b) – currently reads: *'the person should be examined to see if he or she needs to be assessed against the assessment or treatment criteria'*. In line with the previous request, we suggested this provision be changed to: 'the person should be examined to *confirm or negate* if he or she needs to be assessed against the assessment or treatment criteria'.

34. Handover of person taken into protective custody:

(1) – currently reads: *'An MHO or police officer who takes a person into protective custody* – (a) *'must escort the person to an approved assessment centre (or ensure another MHO or police officer does so'*. To this provision, we request the following addition: 'as soon as possible, and not exceeding 2 hours'. (Or the decided "maximum timeframe").

Recommendation 13. That clearer maximum time limits are articulated regarding the length of time a person may be held in protective custody before they are assessed, and clearer delineation be made between those who have been assessed and those who remain unassessed in regards to protective custody.

6.1.4 For safety and as a 'last resort'

Anglicare requests that the Bill make more explicit that a use of force, restraint or seclusion are subject to that treatment being deemed necessary for safety and used as 'a last resort'.

For example: **Part1.Div 2.3 (p15-19) Interpretation** -

"Chemical restraint" – currently reads: *'means medication to control the conduct of the person to whom it is given'.* We suggest this interpretation be changed to reflect a focus on safety, for example: 'means medication to ensure the safety of the person to whom it is given, and others'.

"Mechanical restraint" – As above.

Note: some consumers and staff deem mechanical restraint inappropriate, given recent advancements in chemical restraint measures.

"Physical restraint" - currently reads: *'means bodily force that controls a person's freedom of movement'.* We suggest the following be added: 'for their safety or the safety of others'.

Part4.Div 3.SubD2.77 (p103) "Seclusion" -

Currently reads: *'means the deliberate confinement of an involuntary patient or forensic patient, alone, in a room or area that the patient cannot freely exit'*. We suggest the following be added: 'the deliberate confinement of an involuntary patient or forensic patient in a secluded area for their safety or the safety of others'. To ensure the mental safety of the patient, this decision must come with a mandated requirement for regular monitoring, and a clear plan for how they will be returned to a social setting as soon as possible (documented on case notes).

Recommendation 14. That the Bill clearly articulates that the use of force, restraint and seclusion are for safety and will only be used as a last resort.

Service users consulted in this review report that if a patient has mental capacity (is voluntary) but refuses recommended treatment, they can become involuntary, based on their refusal to consent to treatment. We request that throughout the Bill, a statement is included that precludes 'refusal' from being interpreted as 'mental incapacity'. Anglicare understands that a difficult line needs to be drawn here, and recommend that a safeguard be included within this Bill that ensures 'refusal alone' is not cause for an assessment of 'mental incapacity'. Examples include:

Part1.Div 2.8 (p29) Presumptions as to "mental capacity" of persons other than children -

We believe a statement needs to be included regarding the case of a person who, with 'mental capacity', refuses to undertake recommended treatment. For example, add: '(3) (c) 'Assessment of mental capacity must occur before consent is attained or denied. Refusal of consent by a person with mental capacity does not thereby deem them to be lacking in mental capacity'. (Note: this specific recommendation arises from anecdotal recognition by service users that they have at times become involuntary patients because they, with mental capacity, refused a specific treatment).

Part4.Div 1.49 (p73) Affirmation or discharge of assessment order -

(3) – currently reads: *'To affirm the assessment order, the approved medical practitioner must be satisfied that-'*. We request the following safeguard is added:

Add: (9) 'Refusal to consent to treatment is accepted if a person is assessed to have mental capacity'.

Recommendation 15. That the right for patients to refuse treatment is articulated throughout the Bill; and 'refusal alone does not imply mental incapacity'.

6.1.5 Review and notifications of support person

Anglicare believes the regularity and frequency of reviews needs to be made more explicit within the Bill. For example, we agree with a maximum period of 3 months for a patient to go without a review, and request these be made more explicit throughout the Bill. Specifically in relation to treatment orders, **Part4.Div 2. 63(p85) Duration of treatment order -**

Currently reads – *'A treatment order, unless sooner discharged under this Division, continues in effect for such period not exceeding 6 months (calculated from the precise time it is made) as the Tribunal specifies in the order'*. We request that all treatment orders be reviewed at a maximum of three months, in order to asses the effectiveness of the imposed treatment plan on the mental health of the patient.

Recommendation 16. That the Bill require the intended frequency of reviews be documented within assessment orders, treatment orders, and patients' treatment plans, to a maximum of three months.

Anglicare believes that a nominated support person should be notified at key treatment transition points. This recommendation centres around our belief that social support nurtures mental health, but this recommendations is also related to a rights-based perspective. Specifically, in relation to **Part4.Div 2. 63-70(p85-96)**:

64. Action to be taken by Tribunal on making treatment order:

Again, we believe the nominated support person should be notified of the making of a treatment order, therefore request that an additional requirement be added to (b) – currently reads: *'give notice to that effect and a copy of the order to-'*

Add: '(v) the nominated support person for the patient, along with contact details for that person. If a nominated support person is unavailable, this must be documented within the patient's clinical record and in the treatment order'.

65. Ensuring patient presents for treatment, &c.:

We believe a nominated support person should be notified if a request for escort has been made, therefore request that an additional requirement be added to (2) –currently reads: *'For the purposes of subsection (1)-'*

Add: '(d) a nominated support person for the patient is notified of the intended escort by the controlling authority of the approved facility. If a nominated support person is unavailable, this must be documented within the patient's clinical record and in the treatment order'.

67. Variation of treatment order:

(1) - currently reads: 'The CCP may vary a treatment order at any time-'. We wish to ensure that CCP's are required to attempt to contact a nominated support person in the case of varying a treatment order. We suggest the following addition:

Add: (c) if the CCP varies a treatment order, they are to attempt to notify a nominated support person for the patient. If a nominated support person is unavailable, this must be documented within the patient's clinical record and in the treatment variation order'.

68. Renewal of treatment order:

We would like to see reference to a nominated support person made in an application for renewal of a treatment order. We request consideration is given to requiring an application to include a documented reference to a nominated support person, in favour or otherwise, of the proposed renewal of treatment order. Again, if a nominated support person is unavailable, this must be documented within application for treatment renewal. Therefore, we request the following changes be made:

Add: (3) (e) 'a statement by the patient's nominated support person regarding their observations of the effectiveness of the current treatment regime, their observations of the current state of the patient's mental health, and their availability to attend a hearing in the matter'.

Add: (4) (b) currently reads: *'give a copy of the application to-'* (ii) 'a nominated support person for the patient. If a nominated support person is unavailable, this must be documented within the application for treatment renewal'.

Add: (7) (d) 'the nominated support person agrees, on the basis of their observations that the patient is still benefiting from the treatment regime'.

(8) – currently reads: *'Under this section, a treatment order may be renewed for-* (a) *if it has not previously been renewed a period not exceeding 6 months, (b) in any case, a period not exceeding 12 months'.* We are concerned about the length of treatment orders, without requirement of a review is not made explicit enough in the body of the Bill. Therefore, we request the following changes be made: (a) if it has not previously been renewed a period not exceeding *3* months, (b) in any case, a period not exceeding *6* months'.

(9) – currently reads: *'On reviewing a treatment order, the Tribunal is to-'*. Again, we request that the Tribunal be required to notify a nominated support person for the patient if the treatment order is to be renewed, meaning the following addition:

Add: (b) '(v) the nominated support person for the patient. If a nominated support person is unavailable, this must be documented within the patient's clinical record and in the treatment order'.

69. Discharge of treatment order by medical practitioner or Tribunal:

We are concerned that a patient may be discharged without a requirement to notify a nominated support person, let alone require establishment of a care plan (that includes plans for housing and support). This omission to notify a nominated support person may have serious implications for the level of support a patient will receive upon discharge, (dependent on many factors, including the support a nominated person can offer at a given time), with serious ramifications for their mental health. For this reason, we request the following addition be made, as a minimum:

Add: (5) 'On signing the discharge paper, the approved medical practitioner is to – (a) give a copy of the discharge paper to-' (ii) a nominated support person. If a nominated support person is unavailable, this must be documented within the patient's clinical record and in the discharge plan'.

Add: (6) 'The discharge paper must include a detailed discharge plan, including the contact details and statement of availability of at least one nominated support person, a plan for short- and medium-term accommodation, and income. A copy of the discharge plan shall be kept in the patient's clinical record, and constitute part of the person's ongoing treatment plan (which will include a plan for community-based support).

70. Discharge of treatment order by change in patient status:

We believe a nominated support person should be notified if a treatment order is taken to have been automatically discharged, therefore request that an additional requirement be added to (2) – currently reads: *'If a treatment order is automatically discharged under this section, the treating medical practitioner is to-*

Add: (b) '*give a copy of the discharge paper to-*' (ii) 'a nominated support person for the person. If a nominated support person is unavailable, this must be documented within the patient's clinical record and in the discharge paper'.

Recommendation 17. That the Bill stipulate a responsibility for mental health practitioners and the Mental Health Tribunal to notify a support person at key treatment transition points, and if unavailable, a note made in clinical records to that effect.

6.2 Training

As has been made clear, Anglicare believes it is important for mental health treatment services to be operating from a mental health promotion and recovery basis. It is our understanding that toward best practice in mental health care, all mental health practitioners require training in mental health promotion and mental health recovery principles in order to both understand the need for, and be able to skilfully apply, mental health promoting practices in all mental health care settings. This requirement relates to all mental health practitioners, including medical practitioners, nurses, and Chief Psychiatrists. Training in these areas forms an important foundation for the establishment of a mental health care service system that delivers best practice service standards, including in medical treatment and clinical settings. From this perspective, and to ensure all staff are operating from the same principles, we deem it essential that training in these areas is mandatory for those with responsibility for implementing the Act. For these reasons, we request the following changes in relation to expertise:

Part1.Div 1.18-19 (p39-40) Appointment -

18 (2) Chief Civil Psychiatrist

We request the following addition: '(c) trained in mental health promotion and mental health recovery principles'.

19 (2) Chief Forensic Psychiatrist

We request the following addition: '(c) trained in mental health promotion and mental health recovery principles'.

Part1.Div 3.31-32 (p54-57) Approved personnel –

31 (2) Approved medical practitioners and nurses

We request the following addition: '(c) trained in mental health promotion and mental health recovery principles'.

32 (2) Approved mental health officers

Currently reads: '*The persons (or, as the case may be, all members of the class of persons) so approved must have skills, qualifications or experience relevant to the responsibilities of MHO's under the relevant statutory provisions'*. We request the following change: 'The persons (or, as the case may be, all members of the class of persons) so approved must have skills, qualifications or experience relevant to the responsibilities of MHO's under the relevant statutory provisions, including training in mental health promotion and mental health recovery principles'.

Recommendation 18.

That the Bill require all mental health practitioners, mental health officers, Chief Psychiatrists and Official Visitors to undertake training in mental health promotion and mental health recovery principles.

6.3 Chief Civil Psychiatrist and Chief Forensic Psychiatrist

6.3.1 Powers

We request that consideration be given to inclusion of provisions that require Chief Psychiatrists to seek the consent of a nominated support person before enacting their power of direct intervention. This request has relevance for **Part2.Div 2.22.1-8 (p41-44) Power of direct intervention -**

(1) – currently reads: *'A Chief Psychiatrist has, in prescribed matters within his or her jurisdiction, the power to intervene directly with regard to the assessment, treatment and care of any patient'.* We request that consideration be given to the following change: 'A Chief Psychiatrist has, in prescribed matters within his or her jurisdiction, the power to intervene directly with regard to the assessment, treatment and care of any patient, in collaboration with a nominated support person. If a support person has not been nominated, or if a nominated person is unavailable, this must be documented within the patient's clinical record, and the Chief Psychiatrist authorisation stands alone'.

(3) – *currently reads: 'However, the power of intervention is only exercisable if the Chief Psychiatrist* - (a) *'has made inquiries into the relevant prescribed matter'.* To ensure patients' have the opportunity to be supported in all matters concerning their mental health, we request consideration be given to changing this provision to become: 'has made inquiries into the relevant prescribed matter, including communication with the patient's nominated support person. If a support person has not been nominated, or if a nominated person is unavailable, this must be documented within the patient's clinical record, and the Chief Psychiatrist authorisation stands alone'.

(5) - *currently reads: 'The Chief Psychiatrist, by the same or a different notice, may also do either or both of the following:* (a) *'issue consequential directions for the future assessment, treatment or care of the patient'.* To ensure patients' have the opportunity to be supported in all matters concerning their mental health, we request consideration be given to changing this provision to become: 'issue consequential directions for the future assessment, treatment or care of the, in collaboration with the patient's nominated support person. If a support person has not been nominated, or if a nominated person is unavailable, this must be documented within the patient's clinical record, and the Chief Psychiatrist authorisation stands alone'.

Recommendation 19.
That the Bill identify that the powers of the Chief Psychiatrists relating to direct intervention include responsibilities to both patients and support people, including an expectation that they will communicate with patients' support people at key treatment transition points.

6.3.2 Independence

Whilst acknowledging the relative independence of Chief Psychiatrists, we wish the Bill to recognise that Chief Psychiatrists must recognise they are accountable to Tasmanians experiencing mental illness. For this reason, we request consideration be given to changing this provision to include that sentiment. This request has relevance for **Part2.Div 2.23 (p44) Independence.**

The provision currently reads: *'Notwithstanding the State Service Act 2000, in acting or forming any opinion in clinical matters a Chief Psychiatrist is not subject to the direction of the Minister, the other Chief Psychiatrist or any other person*'. To this statement, we wish to add: 'however it is recognised that a key responsibility of Chief Psychiatrists is to seek to work collaboratively with the Mental Health Tribunal, Mental health practitioners, patients and nominated support people, towards an aim of maximising the mental health of the Tasmanian community, including those experiencing an episode of mental illness.

Recommendation 20.
That the Bill identify that the powers of the Chief Psychiatrists relating to independence are based on their position of assumed responsibility for supporting Tasmanians experiencing an episode of mental illness.

6.4 Mental Health Tribunal

6.4.1 Interim treatment orders

Given the importance for some Tasmanians of the decisions of the Mental Health Tribunal (especially at times of extreme vulnerability), and given that Tribunal members carry a range of qualifications that may not include mental health expertise, Anglicare does not support decision-making power by one member of the Mental Health Tribunal in relation to any issue. We recommend that a minimum of two members be engaged in any decision currently referred to within the current Bill. This request has relevance for **Part4.Div 2.57 (p80) Interim treatment order** -

(1) – currently reads: *'Despite section 55, a single member of the Tribunal may make an interim treatment order in respect of a patient if, but only if, the member is satisfied that-'.* As a minimum, we request that interim treatment orders be made with a minimum of two Tribunal members.

(5) – currently reads: *'Any Tribunal member may revoke or amend the interim treatment order at any time'.* As above, we request that this be changed to read: 'Any pair of two Tribunal members may revoke or amend the interim treatment order at any time'.

Recommendation 21.

That where the Bill currently refers to interim decision-making powers of one member of the Mental Health Tribunal, this be changed to two members.

6.5 Transport

Some service users consulted report that when transported to, between, or from acute inpatient settings they have sometimes been 'bundled into a paddy wagon'. Given they have not committed, been charged with, or convicted of a crime, this treatment is inappropriate and degrading. Anglicare requests that in all cases, if an alternative vehicle to a police vehicle is available to be used to transport people requiring protective custody, it is used. The least preferred transportation is a police 'paddy wagon', and this should not be used in any but the most extreme cases of dangerous behaviour.

Recommendation 22.

That the Bill identifies specific preferred transport options for patients (during protective custody, transfer and discharge), including a preference for non-police vehicles, and if police vehicles must be used, cars are preferred.

6.6 Discharges into homelessness

Service users consulted for this submission and previous research evidence demonstrates that patients discharged from Tasmanian inpatient mental health treatment settings are frequently discharged into homelessness. It is important that the new Mental Health Act takes on a legislative role in preventing homelessness as a result of discharge from inpatient settings. We

recommend the Bill requires that mental health practitioners develop discharge plans, and that practitioners are required to record discharge plans within treatment plans, including plans for accommodation, transportation and social support upon discharge. Anglicare believes this issue is so important that the Mental Health Tribunal should hold mental health treatment services to account for facilitating discharge plans via a requirement to report discharge plans on a monthly basis, including cases where patients were discharged into homelessness.

Recommendation 23.
That the Bill identifies a requirement that approved facilities ensure patients have comprehensive discharge plans in place before discharge, including plans for accommodation, transportation and social support.

Recommendation 24.
That the Bill identify a requirement that approved facilities must report patient discharge plans and subsequent discharge processes to the Mental Health Tribunal, including occurrences when patients were discharged into homelessness.

6.7 Rights to refuse treatment

Family members consulted for this submission report that Section 87 of the current Mental Health Act has provided service users and family members with some power to refuse a particular treatment or response from staff within acute inpatient settings. If this section is to be removed from the new Act, a replacement statement or provision will need to be included. (This might be based on a statement of human rights, linked with relevant Australian Charters, as suggested within Recommendation 1).

Recommendation 25.
That statements of patient and family member rights are stated clearly within the new Bill, including the right to refuse treatment and/or request another form of treatment.

7. Conclusions

We consider this to be a Draft Bill 'nearing completion'. In the context of an under-resourced mental health treatment system, both the Tasmanian Government and the community need to be looking for alternative ways to support the mental, emotional and social health of people living with mental ill health - including via intra-sector linkages, application of recovery principles, and the strengthening of peoples' social support networks. The development of this Bill and the establishment of a new Mental Health Act offer an ideal opportunity to legislate these cost-effective solutions.

This proposed Act has the potential to both promote and mandate a service culture within mental health care that will help to support mental health and recovery. Our suggestions offer a practical way of establishing a legal framework that holds mental health promotion as a predominant framework across all mental health care efforts (including treatment). Service users consulted report that Tasmania's mental health treatment services lag behind in applying recovery principles within practice. This legislative review provides an important opportunity to encourage a service culture that promotes mental health across the spectrum of mental health services; therefore it is very important that we get the fundamental principles, provisions and interpretations right within this Act – for the benefit of service users, service providers, and the wider community.

Without appropriate philosophical foundations, language and progressive service principles in each provision, decision-making process, directive and practice directive within this Act, the Tasmanian mental health treatment sector will face continuing difficulties. Our suggested changes seek to alleviate pressures already felt by treatment services by promoting healthier settings for both staff and patients. With these fundamentals right, we will be building the 'health' of the whole mental health care service system, with benefits for service users, service providers, and with spin-off benefits for the whole Tasmanian community.

Anglicare looks forward to working within a refined legislative framework for Mental Health based on an Act that demonstrates leadership in mental health care. We acknowledge that the new Mental Health Act will have a key role in influencing the culture of Tasmania's mental health service system into the future, and in particular, mental health treatment.

We understand that mental health care already places a significant health cost for the Tasmanian community, and recognise that requests embedded in this submission require resourcing. We also recognise that savings will be made by the Tasmanian community if we get mental health care 'right'. Therefore, this submission comes with a fundamental request that the Tasmanian Government prioritise adequate funding for essential services across our mental health care service system, including mental health treatment.

8. References

Australian Commission on Safety and Quality in Health Care 2008, *The Australian Charter for Healthcare Rights*, viewed September 2011, <http://www.health.gov.au/internet/safety/publishing.nsf/content/PriorityProgram-01

Council of Australian Governments 2006, *A National Action Plan on Mental Health* viewed September 2011, <http://www.coag.gov.au/coag_meeting_outcomes/2006-07-14/docs/nap_mental_health.pdf

Department of Health and Aging 2009, *Fourth National Mental Health Plan (2009-2014)*, Australian Government, viewed September 2011, <http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-f-plan09

Department of Health and Human Services 2006, *Tasmanian Mental Health Services Strategic Plan (2006-2011)*, Tasmanian Government, viewed September 2011, <http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/38507/Mental_Health_Strategic_Plan_1.pdf

Department of Health and Human Services 2006, The Tasmanian Charter of Health Rights and Responsibilities, Tasmanian Government, viewed September 2011, <http://www.healthcomplaints.tas.gov.au/__data/assets/pdf_file/0004/145318/CHARTER_July_2006.pdf

Mrazek, P & Haggerty, R (1994), *Reducing the risks for mental disorders: frontiers for preventative intervention research*. National Acedemy Press, Washington DC, USA.

United Nations 1948, *Universal Declaration of Human Rights*, viewed September 2011, <http://www.un.org/en/documents/udhr/

VicHealth Victorian Health Promotion Foundation 2011, *Opportunities for social connection*, viewed September 2011, <http://www.vichealth.vic.gov.au/~/media/ResourceCentre/PublicationsandResources/Social%20connection/opportunities_for_Social_Connection_Summary_Nov10.ashx