Australian College of Mental Health Nurses
Response to the Tasmanian Mental Health Bill
2011 Exposure Draft

22 September 2011
Introduction

The Australian College of Mental Health Nurses (ACMHN) is the peak professional membership and advocacy organisation for mental health nurses in Australia. It works on behalf of members to advance the quality, status and recognition of the mental health nursing profession and to enhance the mental health of the community.

ACMHN seeks to represent the profession at all levels of government and across all health service sectors. In addition, the ACMHN sets standards for practice, supports mental health nursing research and provides a forum for collegial support, networking and ongoing professional development for its members. The ACMHN has branches in each state and territory, including Tasmania.

Mental health nurses are registered nurses who hold a recognised specialist qualification in mental health. Taking a holistic approach, guided by evidence, the mental health nurse works in collaboration with people who have mental health issues, their family and community, towards recovery as defined by the individual.¹

ACMHN members work in a range of settings including public and private clinical mental health services; rehabilitation and recovery programs; community managed mental health services; primary health care settings including Divisions of General Practise and other organisations that access Commonwealth funded mental health programs (such as the Mental Health Nurse Incentive Program) in order to provide an appropriate response to people and families seeking the involvement of a specialist mental health nursing professional.

The ACMHN welcomes the opportunity to respond to the Tasmanian Mental Health Bill 2011 Exposure Draft. Members of the ACMHN have participated in consultation processes held in July 2011. In addition, many mental health nurses have contributed to the review of the Mental Health Act 1996 through their workplaces and other mental health organisations.

¹ ACMHN Standards of Practice 2010
Object, purpose and principles
Mental Health Nurses welcome the review of the *Mental Health Act 1996* and applaud the intention of the Mental Health Bill to be rights focussed and consumer centred, as stated on page 9 of the Explanatory Guide to the Exposure Draft of the Bill. Tasmania’s approach to modernise the law in this way is consistent with the recovery oriented approach inherent in contemporary mental health approaches such as that advocated by the ACMHN in the Mental Health Nurse Standards of Practice 2010. The ACMHN Standards of Practice reflects the aspiration of Mental Health Nurses to work holistically, guided by evidence, and in collaboration with people who have mental health issues inclusive of their family and community, towards recovery.

The ACMHN is pleased to see the Mental Health Service Delivery Principles contained within the Mental Health Bill will underpin the actions undertaken under this legislation. However, the ACMHN believes the rights focus of the Bill could be strengthened by including this focus in the Objects of the Act. For example, by adding the following to 13(a):

> “in such a way as to retain their rights, dignity and self-respect to the extent that is consistent with their protection, the protection of members of the public and the proper delivery of mental health services”

The Bill could also be strengthened by explicitly referring to a recovery oriented approach. Including these elements within the Objects of the Act would ensure that there is no doubt in the future that any actions taken under the Act are to be rights focussed.

The ACMHN would also draw attention to Clause 1(e) of the Principles which refer to early detention. It is assumed that this should refer to early detection.

**Recommendation**
The ACMHN recommends that the Objects of the Act (Clause 13) explicitly refer to assessment, treatment and care that retains the rights, dignity and self respect of people with mental illness and promotes, to the extent possible, recovery from mental illness.
Impact on Mental Health Nursing workforce

The Explanatory Guide to the Mental Health Bill 2011 Exposure Draft recognises the importance of providing clinicians with clarity around their roles, responsibilities and obligations. Mental Health Nurses play a key role in the implementation of mental health legislation and it is essential that they have comprehensive and consistent understanding of their responsibilities and obligations under the legislation.

It is important that service and funding constraints do not become an obstacle for modernisation of the law. It is critical that the issue of resources is responsibly articulated by the State Government. The College contends that the Governments must appropriately resource this legislative change so that Mental Health Nurses, other professionals and mental health service providers can provide services that meet the legislative requirements and support the human rights of mental health consumers.

Recommendation

Mental Health Nursing workforce implications, including training requirements, must be fully funded with commitments for ongoing resources to ensure the legislative requirements can be implemented for the benefit of our communities.

Administration of the Act – Part 2

Approved Nurses

The ACMHN advocates that all people with mental illness have the right to access care from mental health nurses with specialist mental health knowledge, skills and qualifications. While the ACMHN values the skills held by nurses who have extensive experience in mental health, it believes that the standard for an approved nurse under this legislation should be a Registered Nurse who has a recognised specialist mental health nursing qualification and defined scope of practice in Mental Health Nursing.
**Recommendation**

Only Registered Nurses who hold a recognised specialist mental health nursing qualification and have defined scope of practice in Mental Health Nursing should be eligible to be approved nurses under this legislation.

**Mental Health Officers**

The ACMHN is pleased to see that the Bill includes the addition of Ambulance Officers, who are qualified Paramedics as Mental Health Officers (MHO). We support the requirement that Mental Health Officers must be reappointed after a period of time has elapsed. However, we believe that MHOs who do not have qualifications in mental health, for example police and paramedics, should be appointed for a period of 3 years rather than 5 years.

**Recommendation:**

That MHOs who do not have a qualification in mental health be appointed for a period of 3 years.

**Utilisation of Mental Health Nurse Practitioners**

ACMHN propose that consideration should also be given to providing an increased role for Mental Health Nurse Practitioners. It is expected that in future years, there will be an increase in the number of nurse practitioners in all areas, including mental health. The level of experience, qualification and Mental Health Nursing competencies required to become a Mental Health Nurse Practitioner may provide for greater use of these highly qualified and experienced nursing professionals under this legislation.

It appears that in response to the lack of access to psychiatrist in all circumstances, the legislation extends authority for some functions to medical practitioners. Nurse Practitioners with a scope of practice in mental health have qualifications, extensive experience and advanced practice skills in mental health. In general, Mental Health Nurse Practitioners will be well placed, and in some circumstances, better placed to undertake functions allocated to medical practitioners under the Act. Areas for consideration in regards to this could be the provision of certain treatments and some staged order assessment responsibilities.
**Recommendation**  
The increased scope of practise of Mental Health Nurse Practitioners should be reflected within the modernised Mental Health legislation.

**Establishment of Chief Mental Health Nurse**  
The continuation of other roles with legislated functions and powers such as The Chief Civil Psychiatrist and the Chief Forensic Psychiatrist are understood. However, ACMHN also advocates that a new role of Chief Mental Health Nurse be established to provide leadership to the largest component of the mental health workforce – nurses. Failure to incorporate such positions in the legislation ignores the actual workforce mix in mental health services in Tasmania.

The functions of the Chief Psychiatrist include developing guidelines and standards with respect to the provision of mental health services and to give directions in relation to the provision of mental health services at specified mental health service providers. These are functions which it would be appropriate for a Chief Mental Health Nurse to undertake in collaboration with the Chief Psychiatrist, as within mental health services, Mental Health Nurses have primary responsibility for implementing guidelines and standards. In addition, it is important to establish Chief Mental Health Nurse roles to monitor the standard of mental health nursing practice in the provision of mental health services as a means of ensuring mental health consumers receive evidence based nursing care in accordance with the provisions of the legislation.

**Recommendation**  
Chief Mental Health Nurse positions be established with functions and powers relevant to the roles of mental health nurses, for example to establish clinical guidelines in collaboration with the Chief Psychiatrists, and approve nurses for the purposes of the legislation.

**Treatment of Involuntary Patients**  
There are several concerns the ACMHN would like to raise in relation to Part 4 – Involuntary Patients.
The first is that under section 59 – Treatment Criteria, the criteria are written in a way which is unclear whether all criteria as listed from a) through to e) must be met or whether only some criteria must be met. The ACMHN believes that it is appropriate that all criteria must be met and that the section should be amended to make this clearer. Similar clauses, for example, section 42 Assessment Criteria, include either an ‘and’ or an ‘or’ at the end of each point in the list of criteria. The ACMHN believes it would be clearer if section 59 included the word ‘and’ at the end of each of s59 (a) through to s 59(d).

**Recommendation**

Amend section 59 to provide greater clarity that all criteria must be met.

The second concern is that we believe section 76 – Urgent circumstances treatment has the potential to be detrimental to the health and safety of the patient and also to staff due to the probably delay in authorisation to treatment. There are likely to be times when a medical practitioner who is an approved delegate of the Chief Civil Psychiatrist is not available and the circumstances require urgent treatment to be provided. It is of concern to the College that this clause indicates that duty of care is no longer sufficient to provide treatment in an emergency and that treatment authorisation is still required before treatment can be administered. Mental Health Nurses need clarity that their duty of care to their patients, in this context of emergency treatment, overrides this requirement of the Mental Health Act.

**Recommendation**

That the Act clearly indicate that a health professional’s duty of care to their patient in an emergency situation override the requirement to seek authorisation for treatment.

**Appropriate reasons for seclusion and restraint interventions**

Mental Health Nurses are cognisant that seclusion and restraint remain one of the most restrictive interventions that can be used in psychiatry, whereby a person is significantly deprived of their rights. The ACMHN is disappointed that the draft Bill does not contain a clear and explicit statement that seclusion and or restraint should only be used as a last resort, and where it is necessary, that the least restrictive intervention should be used. The ACMHN
believes it is important that the prescribed reasons for placing a patient in seclusion or restraint (section 77 (5) and section 78 (6), should use stronger language to emphasise that these restrictive interventions are a serious infringemment on patient’s human rights. The prescribed reasons should emphasise the severity of the situation and the risk to the patient, other people as the principle factors that guide the decision as to whether to use seclusion or restraint.

The ACMHN is extremely concerned that s 77(5)(d) allows patients to be placed in seclusion in order to provide for the management, good order or security in the hospital. This opens up the possibility that seclusion could be used where the needs of the facility outweigh the rights of the individual without providing any limits or guidance. The ACMHN understands that there are circumstances when a patient may cause damage to their environment and property and we assume that this is the type of situation this reason is intended to address. We contend that the prescribed reasons listed under s 77(5)(a) to (c) are sufficient to provide for the use of seclusion in these circumstances. If a reason such as s 77(5)(d) is to be included in the Act, it must be re drafted so that there is clear guidance as to the rationale for the reason to be included and much stronger constraints around the use of this reason. If the reason is to be included, the language used should be amended to reflect the impact on other people’s rights, rather than the facility itself.

**Recommendation**

The ACMHN recommends that prescribed reasons for seclusion and restraint refer to significant risk of harm to the patient or other people.

**Recommendation**

The ACMHN recommends that s 77(5)(d) to *provide for the management, good order or security of an approved hospital* be removed. If this recommendation is not accepted, the ACMHN strongly urges that the language of this reason be amended to allow for seclusion to prevent the patient cause damage to their environment and property to such an extent that it causes significant disruption to the services and facilities provided to other people.
Standards of monitoring and reporting on seclusion and restraint.

The ACMHN considers that given seclusion and restraint represent a serious infringement on patients human rights, a high level of monitoring and reporting should be imposed on mental health services. The inclusion of timeframes for examinations by medical practitioners and a requirement that the Chief Psychiatrist set a maximum timeframe for any extension beyond 7 hours is a good safeguard. However, the ACMHN believes these safeguards could be strengthened in several ways:

- At all stages in the use of seclusion or restraint, the legislation should vest the decision making function in an approved medical practitioner if available.
- Where a patient is subject to seclusion or restraint, they must be under continuous observation by a registered nurse or registered medical practitioner.
- The 4 hourly interval for examination by a medical practitioner or approved nurse should be reduced to 1 hour intervals and this examination should encompass a review of whether the intervention is still required.

The ACMHN appreciates that these recommendations have implications for the staff ratios in mental health facilities. However, these safeguards would serve to protect the patient and ensure that seclusion and restraint are used only as a last resort, and would encourage services to employ other mechanisms to protect patients from harming themselves and others. Should these recommendations be adopted, it would be essential that staff of mental health facilities, particularly nursing staff are supported to adopt alternatives strategies to seclusion and restraint.

Recommendation

The ACMHN recommends the legislation include the following requirements for all restrictive interventions:

- At all stages in the use of seclusion or restraint, the legislation should vest the decision making function in an approved medical practitioner if available.
- Where a patient is subject to seclusion or restraint, they must be under continuous observation by a registered nurse or registered medical practitioner.
• The 4 hourly interval for examination by a medical practitioner or approved nurse should be reduced to 1 hour intervals and this examination should encompass a review of whether the intervention is still required.

Mental Health Tribunal – Part 10

Mental Health Tribunal – review of assessment orders
The ACMHN is pleased that the Bill increases the scrutiny of assessment orders by the Mental Health Tribunal. This is an additional review that does not currently occur under the existing Act and the ACMHN supports this additional review.

Mental Health Nurse Practitioner members of the Mental Health Tribunal
The ACMHN is aware that medical workforce shortages can impact on the availability of Psychiatrists to be the medical practitioner member of the Mental Health Tribunal. Mental health Nurse Practitioners have extensive experience working with people with mental illness who are subject to mental health legislation. They have the skills and experience to provide the relevant clinical knowledge as members of the Mental Health Tribunal. It is not uncommon for Mental Health Nurses to be members of the equivalent of the Mental Health Tribunal in other Australian jurisdictions.

Recommendation
The ACMHN recommends that Mental Health Nurse Practitioners be an alternative member to a medical practitioner member of the Mental Health Tribunal.

Miscellaneous – Part 11
Finally, the ACMHN would like to raise the issue of how the Bill will interact with Commonwealth legislation as it relates to detention centres. As a result of the recent opening of a detention centre in Tasmania it is necessary that organisations, health professionals and others understand whether and in what circumstances the proposed Mental Health Act will apply to people subject to detention. In particular, the College believes nurses (and other
health professionals) who are providing care to patients in detention centres need to be educated about their responsibilities to those patients in relation to the draft Mental Health Act.