1 Involuntary commitment and treatment (ICT) criteria in Australian and New Zealand Mental Health Acts

	ACT: **Mental Health Act 2015** s58, 66, 101	NSW: **Mental Health Act 2007** ss12, 14, 68	NT: **Mental Health and Related Services Act 1998** s14	QLD: **Mental Health Act 2016** ss3, 12	SA: **Mental Health Act 2009** s21	TAS: **Mental Health Act 2013** ss6, 40	VIC: **Mental Health Act 2014** s5	WA: **Mental Health Act 2014** s25	NZ: **Mental Health Act (Compulsory Assessment and Treatment) Act 1992** s2; Guidelines to the MHA 2012
Mental Illness	The person has a mental illness or mental disorder, and	The person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment and control of the person is necessary:	The person has a mental illness and as a result of the mental illness, without the treatment the person is likely to:	The person has a mental illness; because of the person's illness, the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in:	The person has a mental illness and because of the mental illness, the person requires treatment for	The person has, or appears to have, a mental illness and without treatment, the mental illness will, or is likely to, seriously harm:	The person has a mental illness and because the person has mental illness the person needs immediate treatment to prevent:	The person has a mental illness for which the person is in need of treatment and because of the mental illness, there is:	*Mental disorder*, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it:
Harm	is doing, or is likely to do, serious harm to themself or someone else or	for the person's own protection from serious harm or the protection of others from serious harm and	cause serious harm to himself or herself or to someone else or	imminent serious harm to the person or others or	the person's own protection from harm (whether physical or mental and including harm involved in the continuation/ deterioration of the person's condition) or to protect others from harm and	the safety of the person or others or	serious harm to the person or to another person or	a significant risk to the safety of the person or another, or a significant risk of serious harm to the person or to another or	poses a serious danger to the safety of that person or of others or
Need for care	is suffering, or is likely to suffer, serious mental or physical deterioration and	N/A	suffer serious mental or physical deterioration and	the person suffering serious mental or physical deterioration.	the person has impaired decision making capacity relating to appropriate treatment of the person's mental illness;	the person's health and	serious deterioration in the person's mental or physical health and	a significant risk to the health of the person and	seriously diminishes the capacity of that person to take care of himself or herself or poses a serious danger to their health.
Psychiatric treatment	treatment/care/support is likely to reduce the harm or deterioration (or its likelihood) or result in an improvement in the person's condition and	N/A	the person requires treatment that is available at an approved treatment facility and	N/A	N/A	the treatment will be appropriate and effective in terms of the outcomes referred to in section 6(1) [see additional criteria] and	the immediate treatment will be provided to the person if the person is subject to a temporary treatment order or a treatment order and	treatment in the community cannot reasonably be provided to the person and	N/A
No less restrictive alternative	the treatment, care or support cannot be adequately provided in another way that would involve less restriction of the freedom of choice and movement.	no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person.	there is no less restrictive means of ensuring that the person receives the treatment and	The main objects of the Act are to be achieved in a way that is the least restrictive of the rights and liberties of a person who has a mental illness.	there is no less restrictive means than an inpatient treatment order (ITO) of ensuring appropriate treatment of the person's illness.	the treatment cannot be adequately given except under a treatment order.	there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.	the person cannot be adequately provided with treatment in a way that would involve less restriction.	Ensure that assessment and treatment occur in the least restrictive manner consistent with safety
Additional criteria	The above criteria must be satisfied before a mental health order can be made for a person with decision-making capacity (DMC) who refuses treatment, care or support; the harm or deterioration must be so serious that it outweighs the right to refuse. If a person lacks DMC and refuses treatment, care or support, the only criteria that applies is the existence of a mental disorder or illness. Separate criteria apply to *forensic psychiatric treatment orders*.	In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition, and the likely effect of any such deterioration, are to be taken into account.	the person is not capable of giving informed consent to the treatment or has unreasonably refused to consent to the treatment.	The person does not have capacity to consent to be treated for the illness.	In considering whether there is no less restrictive means than an ITO of ensuring appropriate treatment, consideration must be given, amongst other things, to the prospects of the person receiving all necessary treatment on a voluntary basis or in compliance with a community treatment order.	(i) The person does not have DMC (ii) the treatment will: prevent/remedy mental illness; or manage/alleviate it where possible; or reduce the risks that persons with mental illness may pose to themselves or others; or monitor and evaluate the person's mental state.	N/A	(i) The person does not demonstrate the capacity to make a treatment decision about the provision of the treatment (ii) Decisions regarding ICT must be made with reference to guidelines published by the Chief Psychiatrist.	N/A

Comment: This table displays the criteria that must be apparent before involuntary commitment and treatment can be authorised. This table does not display the processes that must be followed in making and reviewing that authorisation. These processes vary considerably between jurisdictions; the New Zealand MHA, for example, utilises judicial hearings to make compulsory treatment orders (unlike the Australian MHAs). In some Acts, the criteria are listed separately; in others, they are combined (in several cases, they are merged with the definition of mental illness). Recent changes to the MHAs have added additional criteria and process elements to ensure that less restrictive alternatives are utilised. All decisions to order involuntary commitment and treatment under the Australian Acts now require, at a minimum: the person to be suffering from mental illness (or a condition with similar manifestations), a nexus between that illness and serious risks to health and/or personal or public safety, the provision of treatment for that illness, and for there to be no less restrictive means of providing that treatment available. The NZ criteria are slightly broader, as they include 'seriously diminished capacity to take care of oneself'. Increasingly, the MHAs also require an assessment of whether the patient has the capacity to make treatment decisions. This requirement is often included as a Principle or Object of the MHA. Sometimes this requirement is part of the criteria for involuntary commitment and treatment – the new Queensland MHA, for example, prohibits compulsory treatment for a person with decision-making capacity who unreasonably refuses treatment.

2 Capacity of adults to give informed consent to psychiatric treatment in Australian and New Zealand Mental Health Acts

	ACT: **Mental Health Act 2015** ss7-8	NSW: **Mental Health Act 2007**	NT: **Mental Health and Related Services Act 1998**	QLD: **Mental Health Act 2016** ss14, 18	SA: **Mental Health Act 2009** s5A	TAS: **Mental Health Act 2013** s7	VIC: **Mental Health Act 2014** ss68, 70	WA: **Mental Health Act 2014** ss13, 15, 18	NZ: **Mental Health Act (Compulsory Assessment and Treatment) Act 1992,** ss2, 59, 67, 130; *Health and Disability Services Consumers' Rights Regulation 1996* Right 7; *Guidelines to the MH Act 2012* 10.2.1, 11.4
Does a presumption of capacity exist?	Yes; the presumption is rebutted if one of the following elements is lacking:	Yes; the presumption is rebutted if one of the following elements is lacking:	Yes; the presumption is rebutted if one of the following elements is lacking:	Yes; the presumption is rebutted if one of the following elements is lacking:	Yes; the presumption is rebutted if one of the following elements is lacking:	Yes; the presumption is rebutted if he or she is unable to make the decision because of an impairment of, or disturbance in, the functioning of the mind or brain, and one of the following elements is lacking:	Yes; the presumption is rebutted if one of the following elements is lacking:	Yes; the presumption is rebutted if one of the following elements is lacking:	Yes; the presumption is rebutted if one of the following elements is lacking:
Understanding	ability to understand when a decision about treatment, care or support for the person needs to be made; the facts that relate to the decision; the main choices available to the person in relation to the decision; and how the consequences affect the person	ability to understand the information material to the decision	ability to understand the information material to the decision	ability to understand, in general terms – that they have an illness, or symptoms of an illness, that affects their mental health and wellbeing; and the nature and purpose of the treatment; and the benefits and risks of the treatment, and alternatives; and the consequences of not receiving the treatment	ability to understand the information material to the decision	ability to understand information relevant to the decision	ability to understand information given that is relevant to the decision	ability to understand any information or advice about the decision that is required under this Act to be provided; and understand the matters involved in the decision; and the effect. The information includes a clear explanation containing sufficient information to enable the person to make a balanced judgment; identifying and explaining any alternative treatment about which there is insufficient knowledge to justify it being recommended or to enable its effect to be predicted reliably; and warning about any risks	ability to understand the information relevant to the decision, including an explanation of the expected effects of any treatment including the expected benefits and the likely side effects. This should include: details of any drug, dose and method of administration proposed; the likely course of the treatment; intended effects of the treatment on the mental state of the patient, possible side effects; and any other relevant information
Retaining	N/A	ability to retain the information material to the decision	ability to retain the information material to the decision	N/A	ability to retain the information material to the decision	ability to retain information relevant to the decision	ability to remember the information that is relevant to the decision	N/A	ability to retain that information
Using and Weighing	ability to weigh up the consequences of the main choices	ability to use and weigh the information as part of the process of making the decision	ability to use and weigh the information as part of the process of making the decision	N/A	ability to use and weigh the information as part of the process of making the decision	ability to weigh information relevant to the decision	ability to weigh information that is relevant to the decision	ability to weigh the above factors for the purpose of making the decision	ability to use and weigh the information as part of the process of making the decision
Communicating	ability to communicate the decision in whatever way the person can	ability to communicate the decision.	ability to communicate the decision.	ability to communicate the decision in some way	ability to communicate the decision in any manner.	ability to communicate the decision (whether by speech, gesture or other means).	ability to communicate the decision by speech, gestures or any other means.	ability to communicate the decision in some way.	ability to communicate that decision by any means.
Additional criteria	on the basis of what is understood and the consequences that are weighed, make the decision.	N/A	N/A	ability to make a decision about the treatment.	N/A	N/A	N/A	N/A	N/A

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Comment: The NSW, NT and SA Acts contain no capacity test, so the common law test in *Hunter and New England Area Health Service v A* [2009] NSWSC 761 applies. The four-part test set out in that case (understanding/retaining/using and weighing/communicating) is generally applied across the Acts. The Queensland Acts and Tasmanian Acts are the main exceptions. The Queensland Act focuses less on using and weighing information, and more on other aspects of decision-making. The Tasmanian Act adds the qualifier that the decision-making capacity is impaired by 'an impairment of, or disturbance in, the functioning of the mind or brain'.

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3 Regulation of electroconvulsive treatment (ECT) in Australian and New Zealand Mental Health Acts

	ACT: **Mental Health Act 2015** ss145, 149, 153-4, 156-7, 160-2	NSW: **Mental Health Act 2007** ss88-96, *Health Policy Directive PD2011_003*	NT: **Mental Health and Related Services Act 1998** s66	QLD: **Mental Health Act 2016** ss234-6, 507-9; *Guideline for the administration of ECT 2012*	SA: **Mental Health Act 2009** ss42, 90; *ECT Chief Psychiatrist Standard 2013; ECT Policy Guideline 2013*	TAS: **Mental Health Act 2013**	VIC: **Mental Health Act 2014** ss91-99; *ECT: Chief Psychiatrist's Update 2015*	WA: **Mental Health Act 2014** ss192-199; 409-15; *Chief Psychiatrist's Guidelines for the use of ECT 2006*	NZ: **Mental Health Act (Compulsory Assessment and Treatment) Act 1992,** ss59-60, *Guidelines to MH Act 2012 10.4*
Definition of ECT	A procedure for the induction of an epileptiform convulsion in a person. ECT can be administered a maximum of 9 times per authorisation (3 in emergencies).	None listed. Ordinarily, ECT can be administered a maximum of 12 times in a 6 month period.	None listed.	Application of electric current to specific areas of the head to produce a generalised seizure that is modified by general anaesthesia and the administration of a muscle relaxing agent for the treatment of a mental illness.	None listed in the Act. A patient may consent to a maximum of 12 episodes over three months; this total includes an episode used to determine correct doses in the future.	No reference to ECT in the Act or regulations.	Application of electric current to specific areas of a person's head to produce a generalised seizure. A *course* of ECT cannot exceed 12 treatments and must be performed within 6 months.	Treatment involving the application of electric current to specific areas of a person's head to produce a generalised seizure that is modified by general anaesthesia and the administration of a muscle relaxing agent. 12 is the maximum that may be prescribed at a single time.	None listed. A course of ECT is roughly 12 episodes.
If informed consent is not given, who may apply to perform ECT?	Chief psychiatrist (CP) or a doctor.	Two medical practitioners (unless the medical superintendent of the facility refuses to allow it).	Two authorised psychiatric practitioners.	Psychiatrist (preferably with a second opinion from another consultant psychiatrist).	Medical practitioner or mental health clinician. If uncertain, or none of the 7 main indications apply, seek a second opinion from a psychiatrist.	N/A	Authorised psychiatrist.	Medical practitioner.	Responsible clinician.
Criteria the applicant must consider	If reasonable grounds exist to believe that ACAT could make an *electroconvulsive therapy order*, and the person lacks decision-making capacity (DMC) to consent to ECT. Also: a *psychiatric treatment order* (PTO) or a forensic psychiatric treatment order (FPTO) must also be in force.	Clinical condition, history of treatment, and any appropriate alternatives. Is ECT a reasonable and proper treatment and necessary or desirable for the safety or welfare of the patient?	Clinical condition, history of treatment and other appropriate alternatives. Is it a reasonable and proper treatment to be administered and are they likely to suffer serious mental or physical deterioration without it?	The most clinically appropriate treatment alternative for the person having regard to clinical condition and treatment history? Also: patient/family preferences, degree of suffering, need for rapid response, and risk/benefit compared to other treatments.	Mental illness must exist. Indications must be clearly documented in the patient's record. A comprehensive risk/benefit assessment must be carried out. Clinical assessment of cognitive and memory function must be carried out before/during/after.	N/A	Whether there is no less restrictive way to treat, having regard to: views and preferences (and the reasons they're held) of patient about ECT and any beneficial alternatives available; views of carer/parent etc; likely results if ECT is not performed; any second psychiatrist opinion.	Reasons for recommending ECT, and a treatment plan including number of treatments.	None listed in the Act. The guidelines refer to *RANZCP 2007 Clinical Memorandum #12: ECT*. This contains pre-ECT evaluation considerations, such as the necessity of a full medical history and physical examination (including a fundoscopy).
Who hears the application?	ACT Civil and Administrative Appeal Tribunal (ACAT).	Mental Health Review Tribunal (MHRT).	Mental Health Review Tribunal (MHRT).	Mental Health Review Tribunal (MHRT).	Psychiatrist, then the South Australian Civil and Administrative Tribunal.	N/A	Mental Health Tribunal (MHT).	Mental Health Tribunal (MHT).	Second psychiatrist (independent of requesting clinical team) appointed by Review Tribunal.
Criteria that must be considered when hearing the application	Whether the person consents, or has the DMC to consent; their views and wishes (including any advance statement); the views of carers, people at the hearing, any attorney, guardian or nominated person; any alternative treatment, care or support reasonably available; any relevant medical history.	Above criteria, and other info including: whether the patient understands the inquiry, what effect if any medication has on the patient's ability to communicate, and views of the patient and carer/parent.	Whether the person is unable to give informed consent, and whether all reasonable efforts have been made to consult the primary carer.	Whether: ECT is in the patient's best interests; evidence supports the effectiveness of ECT for the particular mental illness; effectiveness of any prior ECT; if a minor – effectiveness of ECT for persons that age.	None listed.	N/A	Above criteria, and capacity to give informed consent.	Above criteria; CP guidelines and approved premises; patient's wishes; views of family/carer's wishes; nature/degree of significant risks of ECT and alternatives; whether ECT is likely to promote health.	Is the treatment in the best interests of the patient? Also: the second psychiatrist must consider the provisions on informed consent in the *RANZCP 2010 Code of Ethics: Principle 5*.
Who can authorise emergency ECT?	CP and doctor must jointly apply to ACAT.	No emergency ECT regime.	Two authorised psychiatric practitioners.	Jointly: Psychiatrist and senior medical administrator.	Psychiatrist.	N/A	Psychiatrist must apply to MHT.	Medical practitioner, with CP approval (CP guidelines apply).	No emergency ECT regime.
Criteria for emergency ECT	Similar to ACAT criteria above (but no PTO or FPTO is in force). The person has a mental illness and ECT is necessary to save the person's life, or to prevent the likely onset of a risk to the person's life within 3 days and the treatment is the most appropriate reasonably available or all other treatments reasonably available have failed.	N/A	Immediately necessary to save life, prevent serious mental or physical deterioration, or to relieve severe distress. Report ECT to MHRT as soon as practicable afterwards.	Need to save the patient's life or prevent the patient from suffering irreparable harm. A second opinion should be sought from another consultant psychiatrist.	Urgently needed for the patient's wellbeing, and in the circumstances it is not practicable to obtain that consent. Notify the CP within one business day afterwards.	N/A	Needed to save the life of the patient or prevent serious damage to health or prevent the patient suffering or continuing to suffer significant pain or distress.	Needed to save life or because there is an imminent risk of the patient behaving in a way that is likely to result in serious physical injury to the patient or another person. Approved premises required.	N/A

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Comment: The regulation of ECT varies widely in most respects across the different Acts. Common features generally include the number of treatments in a course (9–12), the role of tribunals in hearing applications for involuntary ECT, and a separate framework for authorising ECT in emergencies. The main exception is Tasmania, where ECT is not subject to any special regulation. Most Acts have special provisions addressing capacity to consent to ECT, or the matters which the patient must be informed about, or both (see accompanying table 'Special provisions governing informed consent to electroconvulsive treatment (ECT) in Australian and New Zealand Mental Health Acts').

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4 Special provisions governing informed consent to electroconvulsive treatment (ECT) in Australian and New Zealand Mental Health Acts

	ACT: **Mental Health Act 2015** ss8, 27, 30-31, 146, 148, 152	NSW: **Mental Health Act 2007** ss 88, 91-2, 96; *Health Policy Directive PD2011_003*	NT: **Mental Health and Related Services Act 1998** s66	QLD: **Mental Health Act 2016** ss232-5, 507-9; *Guideline for the administration of ECT 2012*	SA: **Mental Health Act 2009** ss232-3; *ECT Chief Psychiatrist Standard 2013; ECT Policy Guideline 2013*	TAS: **Mental Health Act 2013**	VIC: **Mental Health Act 2014** ss90, 93-4, *ECT: Chief Psychiatrist's Update 2015*	WA: **Mental Health Act 2014** ss192-199; 409-15; *CP's Guidelines for the use of ECT 2006*	NZ: **Mental Health Act (Compulsory Assessment and Treatment) Act 1992,** ss59-60, *Guidelines to MH Act 2012 10.4*
Special factors to be considered when determining capacity to consent to ECT	N/A	A person is presumed to be incapable of giving informed consent to ECT if, when consent is sought, the person is affected by medication that impairs the person's ability to give that consent.	N/A	Explicit requirement: the patient must have capacity to give informed consent; this exists if they can understand the nature and effect of a decision relating to the treatment and make and communicate the decision. Consent must be given freely, not obtained by force, threat, intimidation, inducement, deception or exercise of authority.	Consent must be informed and effective.	No reference to ECT in the Act or regulations.	All patients must be presumed to have capacity to give informed consent unless it can be demonstrated that the person lacks capacity when the decision needs to be made. Capacity may develop before or after treatment.	No ECT on under-14s. Psychiatrist must decide if the person has the capacity to give informed consent. Unless given as emergency treatment, ECT must not be performed on a person who refused to give, or was incapable of giving, informed consent. If a patient passively acquiesces to treatment the treating psychiatrist cannot view that lack of protest as consent. Consultation between patient, family and doctor is essential before and during a course of ECT.	Capacity to provide consent may fluctuate. A return of capacity to consent to ECT, or a withdrawal of consent to ECT at any stage, should lead to a re-evaluation of the legal basis of any further treatment. The responsible clinician shall, wherever practicable, seek to obtain the consent of the patient even though that treatment may be authorised by or under the Act without the patient's consent. If a patient passively acquiesces to treatment the treating psychiatrist cannot view that lack of protest as consent. Psychiatrists must consider the provisions on informed consent in the *RANZCP 2010 Code of Ethics: Principle 5*.
Explanations that must be given and understood when establishing consent to ECT	N/A	Fair explanation of the procedures; full description of any possible risks or discomforts, and alternative treatments; full disclosure of any financial interests involving the practitioners and the facility; notice of right to obtain legal/ medical advice, withdraw consent at any time, and have any inquiries answered (and the answers must appear to be understood).	N/A	Full explanation in a form and language likely to be understood about: the treatment; possible pain, discomforts, risks and side effects; alternative methods of treatment available and results of not getting ECT. Patient must understand nature and effect of treatment and right to withdraw consent.	N/A	N/A	N/A	Explain the condition and rationale for ECT with enough information to allow balanced judgement, including risks, benefits, alternatives, recovery period, out of pocket expenses and follow up care. Advise that results cannot be guaranteed.	N/A
Who can provide consent to ECT on behalf of the patient?	Guardian or attorney with authority to give consent for medical treatment.	N/A	Adult guardian or decision-maker for the person, or the Local Court.	N/A	Medical agent or guardian of the patient or by the Tribunal (or parent, if under 16 and lacking capacity).	N/A	A person who has the legal authority to consent on behalf of a minor (under 18).	An adult's enduring guardian or guardian or the person responsible for the adult; parent or guardian if a minor.	N/A
Can the patient refuse or consent to ECT through an advance health directive or enduring power of attorney?	Yes (two witnesses – instead of one – must witness the signatures when advance consent to ECT is given).	N/A	N/A	Yes.	Yes.	N/A	No; the psychiatrist must consider the views and preferences of the patient expressed in any advance statement, but other factors must be regarded when deciding if there is no less restrictive way to provide treatment.	Yes.	N/A
Penalties for performing ECT without obtaining informed consent	Maximum penalty: 50 penalty units, imprisonment for 6 months or both.	Maximum penalty: 50 penalty units.	Maximum penalty: 40 penalty units.	Maximum penalty: 200 penalty units or 2 years imprisonment.	Maximum penalty: $50,000 or 4 years imprisonment.	N/A	N/A	Penalty: $15,000 and imprisonment for 2 years.	N/A

Comment: Most Acts subject ECT to special, additional regulations (when compared to other forms of psychiatric treatment). Most of these regulations contain special provisions governing informed consent. The provisions are designed to ensure that consent is genuinely informed, effective and freely given. Several Acts set out the matters that must be explained (and understood) in considerable detail. Penalties for administering ECT without obtaining informed consent vary widely – from jurisdictions with no penalties listed at one end of the spectrum, to South Australia where the maximum penalty is a $50,000 fine or 4 years imprisonment.

5 Seclusion in Australian and New Zealand Mental Health Acts

	ACT: **Mental Health Act 2015** ss65, 73, 80-83, 107, 144A, 263-4, 266	NSW: **Mental Health Act 2007** ss3, 68, 190; Health Policy Directive 2012/35	NT: **Mental Health and Related Services Act 1998** ss3, 61	QLD: **Mental Health Act 2016** ss5, 253-261, 263	SA: **Mental Health Act 2009 ss7, 34A**	TAS: **Mental Health Act 2013** ss12, 56	VIC: **Mental Health Act 2014** ss10, 105-112	WA: **Mental Health Act 2014** ss5, 211-225	NZ: **Mental Health (Compulsory Treatment and Assessment) Act 1992** s71, Regulation NZS 8134.3
Definition of 'seclusion'	N/A	Confinement of the consumer at any time of the day or night alone in a room or area from which free exit is prevented.	Confinement of the patient at any time of the day or night alone in a room or area from which free exit is prevented.	Confinement of the patient at any time of the day or night alone in a room or area from which free exit is prevented.	Confinement of a person, alone in a room or area from which cannot leave of own volition	Deliberate confinement of an involuntary patient or forensic patient, alone, in a room or area that the patient cannot freely exit.	Sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave.	Confinement of a person being provided with treatment/care at an authorised hospital by leaving the person at any time of the day or night alone in a room/ area from which it is not within the person's control to leave.	Where a consumer is placed alone in a room or area, at any time and for any duration, from which they cannot freely exit.
When may seclusion be used?	If it is the only way in the circumstances to prevent the person from causing harm to themselves or someone else. In emergencies, seclusion may be necessary to safely apprehend a person and remove them to an approved mental health facility (AHMF).	To manage the risk of serious imminent harm only when appropriate, safe alternative options have been considered and trialled. Use the minimum necessary force for the briefest period required in the circumstances.	If no other less restrictive method of control is suitable and it is necessary to provide medical treatment, or to prevent harm to the patient/ others, persistent destruction of property, or absconding.	If there is no other reasonably practical way to protect the patient or others from physical harm. Seclusion must also comply with any reduction and elimination plan.	Only as a last resort for safety reasons, but seclusion is available to ensure treatment and compliance with the Act, and to prevent nuisance or harm to others.	To facilitate the patient's treatment, or to ensure their safety or that of others, or to provide for the management, good order or security of an approved hospital.	If necessary to prevent imminent and serious harm to the person or to another person, and after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable.	If necessary to prevent the person physically injuring him/herself or another, or persistently causing damage to property, and there is no less restrictive means available to prevent this.	If necessary for the care or treatment of the patient, or the protection of other patients.
Where can seclusion be used?	Approved community care facility, an AMHF, or while apprehending a person and taking them to an AMHF.	Mental health facility.	Approved treatment facility.	Authorised mental health service.	No general restrictions listed. If subject to an Inpatient Treatment Order – a treatment centre.	Approved hospital.	Designated Mental Health Service.	Authorised hospital.	Premises designated for the purpose by or with the approval of the Director of Area Mental Health Services.
Who may authorise seclusion?	Chief Psychiatrist (CP) or a community care coordinator. In emergencies, a police officer, authorised ambulance paramedic, doctor or mental health officer apprehending the person and taking them to an AMHF.	Medical superintendent or a medical officer authorised by one (often the senior nurse who leads the response team).	Authorised psychiatric practitioner; or (in an emergency) by the senior registered nurse on duty.	Authorised doctor, or a health practitioner authorised by one.*	Treatment centre staff.	Chief Civil Psychiatrist (CCP), medical practitioner or approved nurse; if a child, only the CCP.	Authorised psychiatrist, registered medical practitioner or the senior registered nurse on duty.	Medical practitioner or, in an emergency, a mental health practitioner.	Responsible clinician or, in an emergency, a nurse or other health professional.
Who else may vary/ revoke the authorisation?	N/A	Medical superintendent, operational nurse manager, senior nurse, or medical officer – preferably a psychiatrist.	Authorised psychiatric practitioner.	Chief psychiatrist or authorised doctor. The authorisation may also allow a health practitioner to end the seclusion.	N/A	CCP, medical practitioner or approved nurse.	Authorised psychiatrist or (if one is not reasonably available) a registered medical practitioner.	Medical practitioner or mental health practitioner or the person in charge of a ward at an authorised hospital.	Responsible clinician.
Who must be notified?	Public Advocate.	Primary carer. If none exists, a family member must be contacted (taking the patient's wishes into account in this matter).	Authorised psychiatric practitioner and an adult guardian or decision maker if the patient has one.	Chief Psychiatrist (if patient has been or will be secluded for over 9 hours in a 24 hour period).	N/A	N/A	Authorised psychiatrist and the Chief Psychiatrist. Also, a parent, nominated person, or guardian.	Medical practitioner and – if there is one, and they did not authorise the seclusion themselves – the treating psychiatrist.	Responsible clinician.
How long can seclusion last?	Minimum period necessary. The CP must ensure an examination by a consultant psychiatrist (or a doctor in consultation with one) at least every four hours.	No express limit. In prolonged cases, comprehensive assessment must be carried out every 24–48 hours, preferably with the carer attending.	Minimum period necessary.	Three hours, and no more than nine hours in a 24 hour period unless a reduction and elimination plan has been made. A single 12 hour extension is lawful.	Minimum period necessary.	Seven hours. Extensions may be authorised by the CCP if the patient has been examined by a medical practitioner.	Until it is no longer necessary to prevent imminent and serious harm to the person or to another person.	Two hours. Extensions may be made if a medical practitioner examines the patient in that period.	Minimum period necessary; note that the patient has a right to the company of others.

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Comment: The NSW Act has the narrowest grounds for authorising seclusion: 'to manage the risk of serious imminent harm only when appropriate, safe alternative options have been considered and trialled.' Other Acts also authorise seclusion on other grounds such as absconding, persistently destroying property and facilitating treatment. The SA Act has the widest grounds, although it is accompanied by a non-mandatory guideline that narrows them considerably. The Acts also vary substantially in respect to who may authorise seclusion, who must be notified, and the length of time seclusion can be applied. *The Qld Act also refers to 'emergency seclusion', which may be authorised for one hour by a health practitioner if there is no other reasonably practicable way to protect the patient or others from physical harm. An authorised doctor must be notified as soon as practicable.

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6 Restraint in Australian and New Zealand Mental Health Acts

	ACT: **Mental Health Act 2015** ss65, 73, 80-83, 107, 144A, 263-4, 266; ACT Policy – Restraint of a Person – Adults Only CHHS16/025 2016	NSW: **Mental Health Act 2007** ss3, 68, 190; Health Policy Directive 2012/35	NT: **Mental Health and Related Services Act 1998** ss3, 61	QLD: **Mental Health Act 2016** ss5, 242-253, 268-270	SA: **Mental Health Act 2009** ss7, 34A; Chief Psychiatrist Guideline D0382	TAS: **Mental Health Act 2013** ss12, 57	VIC: **Mental Health Act 2014** ss10, 105-109, 113-116	WA: **Mental Health Act 2014** ss10, 226-240	NZ: **Mental Health Act 1992** s71, Regulation NZS 8134.2
Definition of 'restraint'	*Restraint* is the interference with, or restriction of, an individual's freedom of movement. *Physical restraint* involves physically holding a person to do this. *Mechanical restraint* refers to the use of mechanical restraint device for this purpose. *Restraint by threat* is the direct or implied threat to use restraint. *Forcible giving of medication* is medication given to a restrained person against their will.	*Mechanical restraint* includes items used to restrict a consumer's movement, but handcuffs are unacceptable. *Chemical restraint* is a pharmacological method used solely to restrict the movement of a patient; emergency sedation or rapid tranquillisation or medication used as part of a treatment plan does not count.	*Mechanical restraint* is the application of a device on a patient's body to restrict the patient's movement, but does not include the use of furniture that restricts the patient's capacity to get off the furniture.	*Mechanical restraint* is the restraint of a person by the application of a device to the person's body to restrict the person's movement. It does not include appropriate use of a medical or surgical appliance in the treatment of physical illness or injury. *Physical restraint* is the use by a person of his or her body to restrict the patient's movement.	*Restraint* is the restriction of an individual's freedom of movement by physical or mechanical means. *Physical restraint* is defined as the application by health care staff of hands-on immobilisation or the physical restriction of a person.	*Mechanical restraint* is a device that controls a person's freedom of movement. *Physical restraint* is bodily force that controls a person's freedom of movement. Chemical restraint is medication given primarily to control a person's behaviour, not as treatment.	*Bodily restraint* is a form of physical or mechanical restraint that prevents a person having free movement of his or her limbs, but does not include the use of furniture (including beds with cot sides and chairs with tables fitted on their arms) that restricts the person's ability to get off the furniture.	*Physical restraint* is restraint through the application of bodily force to the person's body to restrict their movement. *Mechanical restraint* is the restraint through the application of a device to a person's body to restrict their movement; this does not include the use of medical devices or furniture.	*Restraint* limits the freedom of movement of the patient. *Chemical restraint* is the use of various medicines to ensure compliance and to render the person incapable of resistance.
When may restraint be used?	If necessary and reasonable to safely apprehend the person, convey them to a mental health facility, ensure they remain in custody, or to prevent the person from causing harm to themselves or someone else. Also: to administer medication authorised by the Chief Psychiatrist (CP) or a Community Care Order.	To manage the risk of serious imminent harm only when appropriate, safe alternative options have been considered and trialled. Any restriction is to be kept to the minimum necessary in the circumstances.	If no less restrictive method is suitable and it is necessary to provide medical treatment, or to prevent harm to the patient or others, absconding or persistent destruction of property.	Mechanical restraint may be used if there is no other reasonably practical way to protect the patient or others from physical harm, the patient is continuously observed, and the restraint complies with any reduction and elimination plan.*	Only as a last resort for safety reasons, but it is available to ensure treatment and compliance with the Act, and to prevent absconding and nuisance.	If it is necessary to facilitate treatment or transfer, or ensure health or safety. Emergency short-term physical restraint of a patient is lawful to ensure attendance or prevent disputes, damage, or disorder.	If necessary to prevent imminent and serious harm to the person or others, or administer treatment, and after all reasonable and less restrictive options have been tried or considered and found unsuitable.	If necessary to provide treatment or prevent the patient physically injuring self/ others, or persistently causing damage to property, and there are no less restrictive means and no significant risk to physical health.	To ensure, maintain, or enhance the safety of the patient, or others. Restraint must be a last resort, with the least amount of force, with appropriate planning, after other interventions have been considered.
Is chemical restraint allowed?	Yes.	No.	Unclear.	Yes.	Yes.	Yes.	Unclear.	Unclear.	No.
Where can restraint be used?	Determined by the Chief Psychiatrist.	Mental health facility.	Approved treatment facility.	High-security authorised mental health service.	Treatment centre.	Approved hospital or assessment centre.	Designated mental health service.	Authorised hospital.	Area Designated by Director of Area MH Services.
Who may authorise the form and duration of the restraint?	Unless during apprehension, only the Chief Psychiatrist, Care Coordinator, person in charge of the mental health facility, or the Emergency Medicine Specialist.	Medical superintendent of a facility, or a medical officer authorised by one.	Authorised psychiatric practitioner; or (in an emergency) by the senior registered nurse on duty.	An authorised doctor may apply to the chief psychiatrist to approve the use of mechanical restraint on a patient.	Treatment centre staff.	For chemical or mechanical restraint, (or physical restraint of a child): only the CCP. Otherwise: a medical practitioner or an approved nurse also.	Psychiatrist, registered medical practitioner or the senior registered nurse on duty. A registered nurse may approve urgent *physical* restraint.	Medical practitioner or mental health practitioner at an authorised hospital or the person in charge of a ward.	Responsible clinician In an emergency, a nurse or other health professional having immediate responsibility for a patient.
Who else may vary/revoke authorisation?	N/A	Medical superintendent, operational nurse manager, senior nurse, or medical officer (preferably a psychiatrist).	If the senior registered nurse has authorised restraint, an authorised psychiatric practitioner may revoke or redetermine.	Chief psychiatrist, authorised doctor or health practitioner in charge of the unit.	N/A	Authorised psychiatrist or (if one is not reasonably available) a registered medical practitioner.	Psychiatrist or (if one is not reasonably available) a registered medical practitioner.	Medical practitioner or mental health practitioner or the person in charge of a ward.	Responsible clinician.
Who must be notified?	Public Advocate.	Primary carer or family member.	Person-in-charge, psychiatrist, guardian.	N/A	N/A	N/A	Chief Psychiatrist, nominated person, guardian, carer.	Medical practitioner and treating psychiatrist.	Inform/consult patient, family/whanau, as practical.
How long can restraint last?	Minimum period necessary. If restraint has a direct negative effect on the person, cease immediately.	Minimum period necessary. In prolonged cases, a comprehensive assessment must be carried out every 24–48 hours.	Minimum period necessary. If the patient is admitted as a voluntary patient: 6 hours.	Three hours, and no more than nine hours in a 24 hour period unless allowed for in a reduction and elimination plan.	Minimum period necessary.	Seven hours, but extensions may be authorised by the CCP if the patient has been examined by a medical practitioner.	Minimum period necessary.	Thirty minutes per order or extension of an order; there is no limit to the number of extensions that may be made.	Minimum time necessary, with monitoring and review that depends on the risks and restraint involved.

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Comment: Several different forms of restraint are defined in the Acts and accompanying regulations. The ACT regulations contain the only reference to 'restraint by threat'. Definitions of 'chemical restraint' are highly inconsistent, making comparison difficult. Depending on the jurisdiction, the use of medication to reduce arousal and agitation may be seen as an acceptable alternative to seclusion and restraint, rather than a form of restraint in itself. The NSW Act has the narrowest grounds for authorising restraint: 'to manage the risk of serious imminent harm only when appropriate, safe alternative options have been considered and trialled.' Other Acts also authorise restraint on other grounds such as absconding, persistently destroying property and facilitating treatment. The SA Act has the widest grounds, although it is accompanied by a non-mandatory guideline that narrows them considerably. The Acts also vary substantially in respect to who may authorise restraint, who must be notified, and the length of time restraint can be applied. *The Qld Act regulates physical and mechanical restraint in different ways. Physical restraint may be authorised if it is the only practicable way to prevent harm (to patient or others), serious damage to property or absconding, or to provide treatment and care.

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7 References to Aboriginal and Torres Strait Islanders and Māori in Australian and New Zealand Mental Health Acts

	ACT: **Mental Health Act 2015***	NSW: **Mental Health Act 2007** ss68, 71, Schedule 1	NT: **Mental Health and Related Services Act 1998** ss4, 7A, 8, 11, 35, 110, 118	QLD: **Mental Health Act 2016** ss5, Schedule 3	SA: **Mental Health Act 2009** ss3, 7	TAS: **Mental Health Act 2013** s3	VIC: **Mental Health Act 2014** ss3, 11	WA: **Mental Health Act 2014** ss4, 50, 80-81, 189, 281, Schedule 1	NZ: **Mental Health Act (Compulsory Assessment and Treatment) Act 1992** ss5-6, 7A
Community, culture and spiritual beliefs	N/A	The cultural and spiritual beliefs and practices of people with a mental illness or mental disorder who are Aboriginal or Torres Strait Islanders should be recognised.	As far as possible, the person's treatment and care is to be appropriate to and consistent with the person's cultural beliefs, practices and mores.	The unique cultural, communication and other needs of Aboriginal and Torres Strait Islanders must be recognised and taken into account; they should be provided with treatment, care and support in a way that recognises and is consistent with Aboriginal tradition or Island custom, mental health and social and emotional wellbeing, and isculturally appropriate and respectful.	Take into account the patients' traditional beliefs and practices.	Personal reasons for granting any patient a leave of absence under this Act include – if the patient is an Aborigine – attending an event of cultural or spiritual significance to Aborigines.	Aboriginal persons receiving mental health services should have their distinct culture and identity recognised and responded to.	Provide treatment appropriate to, and consistent with, their cultural and spiritual beliefs and practices and having regard to the views of their families and, to the extent that it is practicable and appropriate to do so, the views of significant members of their communities, including elders and traditional healers, and Aboriginal and Torres Strait Islander mental health workers.	Any court, tribunal, or person exercising a power under this Act in respect of a person must exercise the power with proper recognition of the importance and significance to the person of the person's ties with his or her family, whanau, hapu, iwi, and family group; and with proper recognition of the contribution those ties make to the person's wellbeing; and with proper respect for the person's cultural and ethnic identity, language, and religious or ethical beliefs.
Extended family	N/A	For the purposes of designating carers, a *relative* of a patient who is Aboriginal and Torres Strait Islander includes a person who is part of the extended family/kin according to the indigenous kinship system of the patient's culture.	For the purposes of designating primary carers, a *relative* of the person includes anyone related to the person through a relationship that arises through Aboriginal customary law or tradition.	*Parent* of an Aboriginal and Torres Strait Islander minor includes a person who, under Aboriginal and Torres Strait Islander tradition, is regarded as a parent of the minor.	If the person is of Aboriginal and Torres Strait Islander descent, that person may be a *relative* of another through Aboriginal and Torres Strait Islander kinship rules, as the case may require.	N/A	N/A	For this Act – if the person is of Aboriginal and Torres Strait Islander descent – a *close family member* of a person includes any person regarded as such under the customary law, tradition or kinship of that person's community.	[See above]
Indigenous mental health practitioners and traditional healers	N/A	N/A	*Aboriginal and Torres Strait Islanders health practitioner* means a person registered under the Health Practitioner Regulation National Law to practise in the Aboriginal and Torres Strait Islander health practice profession (other than as a student).	N/A	When practicable and appropriate, involve collaboration with health workers and traditional healers from their communities.	N/A	N/A	*Health professional* includes an Aboriginal and Torres Strait Islander mental health worker. *Traditional healer*, in relation to an Aboriginal and Torres Strait Islander community, means a person of Aboriginal and Torres Strait Islander descent who uses traditional (including spiritual) methods of healing; and is recognised by the community as a traditional healer.	N/A
Duty to provide Indigenous interpreters	N/A	N/A	N/A	To the extent practicable and appropriate in the circumstances.	N/A	N/A	N/A	N/A	Any court, tribunal, or person exercising a power under this Act in relation to a person must ensure a Māori interpreter if it that is the person's first/preferred language.
Other references to indigenous persons or culture	N/A	N/A	A community visitors panel is, so far as is practicable, to include persons of both sexes and of diverse ethnic backgrounds (including Aboriginal and Torres Strait Islander backgrounds). The same applies to Mental Health Review Tribunals.	N/A	N/A	An *Aboriginal person* is a person who satisfies all of the following requirements: Aboriginal ancestry; self-identification as an Aboriginal person; communal recognition by members of the Aboriginal community.	*Aboriginal person* means a person who is: descended from Aboriginal and Torres Strait Islanders, self-identifies as an Aboriginal person, and is accepted as an Aboriginal and Torres Strait Islander by an Aboriginal and Torres Strait Islander community.	To the extent that it is practicable and appropriate to do so, assessment and treatment provided to a patient who is of Aboriginal or Torres Strait Islander descent must be provided in collaboration with Aboriginal or Torres Strait Islander mental health workers and significant members of the patient's community, including elders and traditional healers.	A practitioner must apply any relevant guidelines and standards of care and treatment issued by the Director-General of Health when deciding: when and how to consult the family or whanau, or the proposed patient or patient; whether the consultation is reasonably practicable; and whether it is in the patient's best interests.

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Comment: References to Aboriginal and Torres Strait Islander peoples and Māori are a feature of the newer Acts. The exception is the New Zealand Act, which acknowledged Māori culture, ethnic identity, language and religious or ethical beliefs and extended family and social groups when it was enacted in 1992. The requirement to consult with the family or whānau of the patient or proposed patient was added in 2000. Most of the Acts now acknowledge Aboriginal and Torres Strait Islander and Māori kinship systems and culture. Several Acts go further (such as NZ and WA), requiring the involvement of interpreting services, traditional healers, and Aboriginal and Torres Strait Islander health professionals. *Although the ACT Act does not directly refer to Aboriginal and Torres Strait Islander peoples and Māori, the Principles respect the right to access treatment, care and support that is sensitive and responsive to the patient's individual needs, including in relation to culture: s6 (f)(i).

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8 Definitions of *forensic* patient and similar terms from Australian and New Zealand legislation

	Where is the term defined?	At what stage in the criminal justice process does the term apply? Bail	Remand at a hospital or secure mental health facility	Custody after a determination that the accused will be fit to plead within 12 months	Custody or supervised release after being found not guilty by reason of mental illness or unfit to stand trial within 12 months	Other stages
ACT	*Mental Health Act 2015* (ACT) (MHA) s127 defines a **forensic patient** as a person in relation to whom a f*orensic mental health order* may be made or is in force. A forensic mental health order means a *forensic psychiatric treatment order* or a *forensic community care order* (Dictionary); the persons to whom these apply or might apply are listed in ss101 and 108. The list includes people who are required by a court to submit to the jurisdiction of the ACAT under the *Crimes Act 1900* (ACT) (CA) Part 13, and people who are 'detainees' – a term defined by the *Corrections Management Act 2007* (ACT) s6.	CA s315D (2); MHA s94 (1) (g)	CA s315D (2)	CA s315D (2)	CA ss318 (2), 319 (2) (b), 323, 324, 328 (3), 329 (b), 334 (1), 335 (2)	Parolees, young detainees and offenders, persons released on licence, detainees (which include all adults held in custody or detention) and persons serving community-based sentences may be subject to a forensic mental health order: MHA ss94, 101 and 108.
NSW	*Mental Health Act 2007* (NSW) (MHA) s4: incorporates the definition of **forensic patient** found in the *Mental Health (Forensic Provisions) Act 1990* (MHFPA) s42. This may include persons belonging to a class prescribed by the Regulations or persons subject to the *Criminal Appeal Act 1912* s7(4) (CAA).	MHFPA s14 (b) (ii)	MHFPA s14 (b) (iii)	MHFPA s17 (3)	MHFPA s24, 25, 27, 39; CAA 7 (4)	N/A
NT	*Criminal Code Act Schedule One* 43A (NT) (CCA) defines a **supervised person** as 'a person who is the subject of a supervision order'. These may be custodial (at a secure care facility or a custodial correctional facility) or non-custodial with conditions: s43ZA (1).	N/A	N/A	N/A	CCA ss43I (2) (a), 43X (2) (a) or (3), 412A (3)	N/A
QLD	The *Mental Health Act 2016* (Qld) (MHA) Schedule 3 defines a **forensic patient** as 'a person subject to a forensic order' and lists three types of forensic order: 'mental health', 'disability' and 'criminal code'. A Forensic Order (criminal code) is defined according to the *Criminal Code 1899* (Qld) (CC). The remaining orders are made by the Mental Health Court under the MHA if considered necessary – because of the person's mental condition – to protect the safety of the community, including from the risk of serious harm to other persons or property.	N/A	Forensic Order (Criminal Code): CC ss 613 (3), 645 (1), 647 (1)	N/A	Forensic Order (mental health): MHA s134 (3) (a) Forensic Order (Criminal Code): CC s647 (2)	A Forensic Order (disability) applies when unfitness for trial or unsoundness of mind is considered to be the result of an intellectual disability, and the person needs care for that disability but not for any mental illness: MHA s134 (3) (b). The Mental Health Court must do one of the following: order no limited community treatment/approve a doctor or senior practitioner to authorise limited community treatment/ order limited community treatment: MHA ss139-140.
TAS	*Mental Health Act 2013* (Tas) (MHA) s68 defines a **forensic patient** as 'a person who is admitted to a Secure Mental Health Unit'. This may be ordered under the *Criminal Justice (Mental Impairment) Act 1999* (CJMIA), the *Sentencing Act 1997* (SA), the *Justices Act 1959* (JA), the *Criminal Code* (CC), the *Youth Justice Act 1997* (YJA) or the *Corrections Act 1997* (CA).	CJMIA s39 (1)(a)	CJMIA s39 (1) (b); JA s47; CC s348; YJA s105	N/A	CJMIA ss18 (2), 31; SA s73	A prisoner or detainee who has a disability or appears to have a mental illness may be removed to a secure mental health unit: CCA s36A (2) or (3). If a youth, YJA 134A (2) or (3) applies.
VIC	*Mental Health Act 2014* (Vic) (MHA) s305: incorporates the definitions of **forensic patient** found in the *Crimes (Mental Impairment and Unfitness to be tried) Act 1997* (CYMIUA) and the *Crimes Act 1914 (Cth)* (CA).	N/A	CYMIUA (Other than Part 5A – Children's Court and Appeals from those proceedings)	N/A	CYMIUA [Other than Part 5A – Children's Court and Appeals from those proceedings], including international forensic patients: s73O; CA s20BJ (1), 20BM	N/A
WA	The *Criminal Law (Mentally Impaired Accused) Act 1996* (WA) (CLA) s23 defines a **mentally impaired accused person** as an accused person in respect of whom an undischarged *custody order* has been made. Custody orders may only apply to persons found not guilty (due to unsoundness of mind or mental unfitness) of offences listed in Schedule One of the CLA.	N/A	N/A	N/A	CLA ss 19 (4) & 22 (1)	N/A
NZ	*Mental Health (Compulsory Assessment and Treatment) Act 1992* (NZ) (MHA) s2 defines a **special patient** as a person who is liable to be detained in a hospital under an order made under the *Criminal Procedure (Mentally Impaired Persons) Act 2003* (CPMIA); the *Criminal Procedure Act 2011* (CPA); the *Armed Forces Discipline Act 1971* (AFDA); and the *Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003* (IDCCR).	N/A	CPMIA ss 23, 35, 44 (1)	N/A	CPMIA ss24 (2) (a), 34 (1) (a) (i). An order may be made following a court martial: AFDA s191 (2) (a). A *special care recipient* may become a special patient if they appear to have developed a mental disorder: IDCCR s136 (5) (a).	If not in custody, an order to detain at a hospital or secure facility may be made: CPA s169. If in custody (before/ during the hearing or trial), or awaiting sentence or the determination of an appeal, a court may order assessment in a hospital or secure facility: CPMIA s39 (2) (c). If imprisoned and in need of psychiatric care, an order seeking transfer to a hospital or secure facility may be made: MHA ss45 (2), 46.

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Comment: No definition of 'forensic patient' (or an equivalent term) is found in legislation from the Commonwealth of Australia or South Australia. The main Commonwealth provisions governing persons who are not guilty by reason of mental illness or unfit to stand trial are set out in the *Crimes Act 1914 (Cth)* Part IB. The main South Australian provisions governing persons who are not guilty by reason of mental illness or unfit to stand trial are set out in the *Criminal Law Consolidation Act 1935* (SA) Part 8A. All the jurisdictions create a framework for detaining persons found to belong to one or both categories or for imposing supervised release. Detention does not necessarily occur in separate forensic facilities (see RANZCP Position Statement 90: Principles for the treatment of persons found not criminally responsible or not fit for trial due to mental illness or cognitive disability). Other categories of forensic patient exist in some jurisdictions, such as bailed defendants and convicted prisoners who have been diagnosed with mental illness.