### 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 s12, 14, 68
**MT:** Mental Health and Related Services Act 1998 s14
**QLD:** Mental Health Act 2016 u3, 12
**SA:** Mental Health Act 2009 s1
**TAS:** Mental Health Act 2013 u6, 40
**VIC:** Mental Health Act 2014 s5
**WA:** Mental Health Act 2014 s5
**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.

#### Harm
- is doing, or is likely to do, serious harm to themselves 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 resulting from the person’s 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 another or
- a significant risk to the safety of the person or 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
- suffer serious mental or physical deterioration and
- the person suffering serious mental or physical deterioration.

#### Psychiatric treatment
- the person requires treatment that is available at an approved treatment facility and
- N/A
- 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.

#### 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.
- N/A
- there is no less restrictive means of ensuring that the person receives the treatment and
- N/A
- there is no less restrictive means than an impatient treatment order (ITO) of ensuring appropriate treatment of the person’s mental illness.
- N/A
- the treatment cannot be adequately given except under a treatment order.
- N/A
- the person cannot be adequately provided with treatment in a way that would involve less restriction.
- N/A

#### 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/modify mental illness; or manage/ameliorate 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

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Disclaimer: These tables have been developed by the RANZCP as at 30 June 2017 in order to allow key provisions in the Mental Health Acts to be compared. They are intended for reference purposes only and are not intended to be a substitute for legal or clinical advice.
## 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 (SA) |
| TAS: | Mental Health Act 2013-17 |
| 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:

#### Understanding
- The person has the 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; and how the consequences affect the person.

#### Retaining
- The person has the ability to retain the information material to the decision.

#### Using and Weighing
- The person has the ability to use and weigh the information as part of the process of making the decision.

#### Communicating
- The person has the ability to communicate the decision.

#### Additional criteria
- The person understands and is able to make a decision about the treatment.

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3

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

|---------------------------|-----------------------------|----------------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|----------------------------------|

Definition of ECT

A procedure for the induction of an epileptiform convolution in a person. ECT can be administered as a maximum of 9 times per authorisation (3 in emergencies).

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.
- Authorised psychiatrist.
- Medical practitioner.
- Responsible clinician.

Criteria the application must consider

If reasonable grounds exist to believe the patient may benefit from an electroconvulsive therapy order, and the person lacks decision making capacity (DMC) to consent to ECT. A forensic psychiatric treatment order (FPTO) or a forensic psychiatric treatment order (FPTO) must also be in force.

Clinical condition, history of the patient, and any appropriate alternatives. Is ECT a reasonable and proper treatment and necessary or desirable for the safety of management of the patient? Any appropriate alternatives. Is ECT necessary and appropriate? Does ECT have the benefit of safety and risk benefit compared to other treatments.

Clinical condition, history of treatment and other appropriate alternatives. Is ECT a reasonable and proper treatment to be administrated and is it likely to suffer serious mental or physical deterioration without it? The most clinically appropriate treatment for the person having regard to clinical condition and treatment history. Also patient’s preferences, degree of suffering, need for rapid response, and risk benefit compared to other treatments.

Criteria that must be considered when the application is heard

Whether the person consents, or the DMC 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.

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; the effectiveness of any prior ECT; if a minor – effectiveness of ECT for persons that age.

Above criteria, and other information including: whether the patient understands the inquiry, what effect any medication has on the patient’s ability to communicate, and views of the patient and carer/parent.

None listed.

Above criteria, and capacity to give informed consent.

Who hears the application?


Who can authorise emergency ECT?

CP and doctor must jointly apply to ACAT. N/A. Jointly: Psychiatrist and senior medical administrator. Psychiatrist. N/A. Psychiatrist must apply to MHT. Medical practitioner, with CP approval (CP guidelines apply). N/A

Who can apply to perform ECT?

- Psychiatrist (preferably with a second opinion from another consultant psychiatrist).
- Medical practitioner or mental health clinician.
- Authorised psychiatrist.
- Medical practitioner.
- Responsible clinician.

Reasons for recommending ECT, and a treatment plan including number of treatments.

Who can appeal to modify or cancel an application for ECT?

- ACT: Appeal Tribunal (ACAT).
- NSW: Mental Health Review Tribunal (MHRT).
- NT: Mental Health Review Tribunal (MHRT).
- QLD: Mental Health Review Tribunal (MHRT).
- SA: Psychiatrist, then the South Australian Civil and Administrative Tribunal.
- TAS: Psychiatrist. Second psychiatrist (independent of requesting clinical team) appointed by Review Tribunal.
- VIC: Tribunal (MHRT).
- WA: Tribunal (MHRT).
- NZ: Second psychiatrist (independent of requesting clinical team) appointed by Review Tribunal.

Criteria for authorising 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 prevent the person from suffering irreparable harm.

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.

Needed to save the life of the patient or prevent serious damage to health or prevent the patient suffering further injury or continuing to suffer significant pain or distress.

N/A

Need 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

Compliance with requirements

No emergency ECT regime.

Disclaimer: These tables have been developed by the RANZCP as at 30 June 2017 in order to allow key provisions in the Mental Health Acts to be compared. They are intended for reference purposes only and are not intended to be a substitute for legal or clinical advice. 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’).
## Special provisions governing informed consent to electroconvulsive treatment (ECT) in Australian and New Zealand Mental Health Acts

<table>
<thead>
<tr>
<th>ACT:</th>
<th>Mental Health Act 2015 ss 27, 30-31, 146, 148, 152</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW:</td>
<td>Mental Health Act 2007 ss 88, 91-2, 96, Health Policy Directive PD011_003</td>
</tr>
<tr>
<td>NT:</td>
<td>Mental Health and Related Services Act 1998 s86</td>
</tr>
<tr>
<td>QLD:</td>
<td>Mental Health Act 2016 s232-5, 50-7, for the administration of ECT 2012</td>
</tr>
<tr>
<td>TAS:</td>
<td>Mental Health Act 2013</td>
</tr>
<tr>
<td>VIC:</td>
<td>Mental Health Act 2014 s192-199; 408-15, CPs Guidelines for the use of ECT 2006</td>
</tr>
<tr>
<td>WA:</td>
<td>Mental Health Act 2014 s192-199; 408-15, CPs Guidelines for the use of ECT 2006</td>
</tr>
<tr>
<td>NZ:</td>
<td>Mental Health Act (Compulsory Assessment and Treatment) Act 1992, ss59-60, Guidelines to MH Act 2012 10A</td>
</tr>
</tbody>
</table>

### Special factors to be considered when determining capacity to consent to ECT

<table>
<thead>
<tr>
<th>ACT:</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW:</td>
<td>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.</td>
</tr>
<tr>
<td>NT:</td>
<td>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.</td>
</tr>
<tr>
<td>QLD:</td>
<td>Consent must be informed and effective.</td>
</tr>
<tr>
<td>SA:</td>
<td>No reference to ECT in the Act or regulations.</td>
</tr>
<tr>
<td>TAS:</td>
<td>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.</td>
</tr>
<tr>
<td>VIC:</td>
<td>No ECT on under-14s. Psychiatrist must decide if the person has the capacity to give informed consent. Unless given an 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 acquires 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.</td>
</tr>
<tr>
<td>WA:</td>
<td>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.</td>
</tr>
<tr>
<td>NZ:</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Explanations that must be given and understood when establishing consent to ECT

<table>
<thead>
<tr>
<th>ACT:</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW:</td>
<td>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.</td>
</tr>
<tr>
<td>NT:</td>
<td>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.</td>
</tr>
<tr>
<td>QLD:</td>
<td>N/A</td>
</tr>
<tr>
<td>SA:</td>
<td>N/A</td>
</tr>
<tr>
<td>TAS:</td>
<td>N/A</td>
</tr>
<tr>
<td>VIC:</td>
<td>Explain the condition and rationale for ECT with enough information to allow balanced judgment, including risks, benefits, alternatives, recovery period, out of pocket expenses and follow up care. Advise that results cannot be guaranteed.</td>
</tr>
<tr>
<td>WA:</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Who can provide consent to ECT on behalf of the patient?

<table>
<thead>
<tr>
<th>ACT:</th>
<th>Guardian or attorney with authority to give consent for medical treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW:</td>
<td>Adult guardian or decision-maker for the person, or the Local Court.</td>
</tr>
<tr>
<td>NT:</td>
<td>Medical agent or guardian of the patient or by the Tribunal (or parent, if under 16 and lacking capacity).</td>
</tr>
<tr>
<td>QLD:</td>
<td>A person who has the legal authority to consent on behalf of a minor (under 18).</td>
</tr>
<tr>
<td>SA:</td>
<td>An adult’s enduring guardian or guardian if a minor.</td>
</tr>
<tr>
<td>TAS:</td>
<td>No reference to ECT in the Act or regulations.</td>
</tr>
<tr>
<td>VIC:</td>
<td>Yes.</td>
</tr>
<tr>
<td>WA:</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Can the patient refuse or consent to ECT through an advance health directive or enduring power of attorney?

<table>
<thead>
<tr>
<th>ACT:</th>
<th>Yes (two witnesses – instead of one – must witness the signatures when advance consent to ECT is given).</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW:</td>
<td>N/A</td>
</tr>
<tr>
<td>NT:</td>
<td>Yes.</td>
</tr>
<tr>
<td>QLD:</td>
<td>Yes.</td>
</tr>
<tr>
<td>SA:</td>
<td>N/A</td>
</tr>
<tr>
<td>TAS:</td>
<td>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.</td>
</tr>
<tr>
<td>VIC:</td>
<td>Yes.</td>
</tr>
<tr>
<td>WA:</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### Penalties for performing ECT without obtaining informed consent

<table>
<thead>
<tr>
<th>ACT:</th>
<th>Maximum penalty: 50 penalty units, imprisonment for 6 months or both.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW:</td>
<td>Maximum penalty: 48 penalty units.</td>
</tr>
<tr>
<td>NT:</td>
<td>Maximum penalty: 200 penalty units or 2 years imprisonment.</td>
</tr>
<tr>
<td>QLD:</td>
<td>Maximum penalty: $150,000 or 4 years imprisonment.</td>
</tr>
<tr>
<td>SA:</td>
<td>N/A</td>
</tr>
<tr>
<td>TAS:</td>
<td>N/A</td>
</tr>
<tr>
<td>VIC:</td>
<td>Penalty: $15,000 and imprisonment for 2 years.</td>
</tr>
<tr>
<td>WA:</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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[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
- **Mental Health Policy Directive 2012/95**

#### NSW:
- **Mental Health Act 2007**: ss3, 68, 190
- **Health Related Services Act 2016**: ss5, 253-261, 263

#### QLD:
- **Mental Health and Related Services Act 1998**: ss3, 61
- **Mental Health Act 2009**: ss7, 34A

#### SA:
- **Mental Health Act 2013**: ss2, 56

#### TAS:
- **Mental Health Act 2014**: ss10, 105-112

#### VIC:
- **Mental Health Compulsory Treatment and Assessment Act 1992**: s71, Regulation NZS 8134.3

#### WA:
- **Mental Health Act 2014**: ss5, 211-225

#### NZ:
- **Mental Health (Compulsory Treatment and Assessment) Act 1992**

#### Definitions and Requirements

- **Definition of ‘seclusion’**
  - N/A

- **Confinement of the patient**
  - The consumer at anytime of the day or night alone in a room or area from which free exit is prevented.

- **Confidentiality of the patient**
  - Information about the patient may vary from one jurisdiction to another.

- **Who must authorise?**
  - N/A

- **Revoke the authorisation?**
  - N/A

- **Who else may vary/revoke the authorisation?**
  - N/A

- **Who may authorise seclusion?**
  - Chief Psychiatrist (CP) or a community care coordinator.

- **Who may be notified?**
  - Public Advocate.

- **How long can seclusion last?**
  - Minimum period necessary. The CP must ensure an examination by a qualified psychiatrist (or a doctor in consultation with one) at least every four hours.

- **When may seclusion be used?**
  - N/A

- **Where can seclusion be used?**
  - Approved community care facility, an AMHF, or while apprehending a 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).**

- **Authority or medical officer – preferably a psychiatrist.**

- **Chief psychiatrist or authorised doctor.**

- **Chief psychiatrist or authorised doctor.**

- **Chief Psychiatrist (CP) or a Medical superintendent or a treatment centre staff.**

- **Chief Civil Psychiatrist (CCP), registered medical practitioner or the senior registered nurse on duty.**

- **Medical practitioner or, in an emergency, a mental health practitioner.**

- **Responsibility clinician or, in an emergency, a nurse or other health professional.**

- **Where it is the only way to prevent the person from causing harm to themselves or someone else.**

- **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 an adult has been or will be secluded the Chief Psychiatrist.**

- **Also, if there is one, and they did not make if a medical practitioner note that the patient has**

- **could also authorise seclusion on other grounds such as abducting, 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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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 abducting, 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.
## 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 CHESG/05-2015

#### 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 a mechanical restraint device for this purpose. Restraint by threat is the direct or implied threat to use restraint.

#### When may restraint be used?

If necessary and reasonable to safely apprehend the person, convey them to a mental health facility, or 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 an essere on a Community Care Order (CCP).

#### Minimum period necessary.

If the patient is admitted as a voluntary patient: 6 hours. If the patient is admitted as a person, guardian, carer. Minimum time necessary, and restraint involved.

### NSW:
- **Mental Health Act 2007**: ss68, 190, Health Policy Directive 2012/05

#### Medical superintendent, or a medical officer (preferably a psychiatrist).

- Authorised psychiatrist practising, 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 patient: 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.

A nurse or other health professional having immediate responsibility for a patient.

### NT:
- **Mental Health and Related Services Act 1998**: ss6, 61

#### Medical superintendent, or a medical officer authorised by one.

- Authorised psychiatrist practising, 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 patient: 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.

A nurse or other health professional having immediate responsibility for a patient.

### QLD:
- **Mental Health Act 2016**: ss242-253, 268-270

#### Person in charge of the mental health facility, or the Emergency Medicine Specialist.

- If the senior registered nurse has authorised restraint, an authorised psychiatrist practising may revoke or redo determine.
- Chief psychiatrist, authorised doctor or health practitioner in charge of the unit.
- 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.
- Chief Psychiatrist, nominated person, guardian, carer.

#### Medical practitioner and treating psychiatrist.

- Inform/conduct patient, family/whanau, as practical.

### SA:
- **Mental Health Act 2009**: ss3, 34A, Chief Psychiatrist Guideline D038

#### Medical superintendent, or a medical officer, or a medical officer (preferably a psychiatrist).

- If the senior registered nurse has authorised restraint, an authorised psychiatrist practising may revoke or redo determine.
- Chief psychiatrist, authorised doctor or health practitioner in charge of the unit.
- 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.
- Chief Psychiatrist, nominated person, guardian, carer.

### TAS:
- **Mental Health Act 2013**: s12, 57

#### Person in charge of the mental health facility, or in charge of an emergency ward.

- If the senior registered nurse has authorised restraint, an authorised psychiatrist practising may revoke or redo determine.
- Chief psychiatrist, authorised doctor or health practitioner in charge of the unit.
- 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.
- Chief Psychiatrist, nominated person, guardian, carer.

#### Medical practitioner and treating psychiatrist.

- Inform/conduct patient, family/whanau, as practical.

### VIC:
- **Mental Health Act 2014**: ss10, 105-109, 113-116

#### Person in charge of the mental health facility, or in charge of an emergency ward.

- If the senior registered nurse has authorised restraint, an authorised psychiatrist practising may revoke or redo determine.
- Chief psychiatrist, authorised doctor or health practitioner in charge of the unit.
- 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.
- Chief Psychiatrist, nominated person, guardian, carer.

#### Medical practitioner and treating psychiatrist.

- Inform/conduct patient, family/whanau, as practical.

### WA:
- **Mental Health Act 2014**: ss10, 226-240

#### Person in charge of the mental health facility, or in charge of an emergency ward.

- If the senior registered nurse has authorised restraint, an authorised psychiatrist practising may revoke or redo determine.
- Chief psychiatrist, authorised doctor or health practitioner in charge of the unit.
- 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.
- Chief Psychiatrist, nominated person, guardian, carer.

#### Medical practitioner and treating psychiatrist.

- Inform/conduct patient, family/whanau, as practical.

### NZ:
- **Mental Health Act 1992**: ss1, 21, Regulation NS2 8134.2

#### Person in charge of the mental health facility, or in charge of an emergency ward.

- If the senior registered nurse has authorised restraint, an authorised psychiatrist practising may revoke or redo determine.
- Chief psychiatrist, authorised doctor or health practitioner in charge of the unit.
- 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.
- Chief Psychiatrist, nominated person, guardian, carer.

#### Medical practitioner and treating psychiatrist.

- Inform/conduct patient, family/whanau, as practical.

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**Disclaimer:** These tables have been developed by the RANZCP as at 30 June 2017 in order to allow key provisions in the Mental Health Acts to be compared. They are intended for reference purposes only and are not intended to be a substitute for legal or clinical advice.
Community, culture and spiritual beliefs

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 culturally 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 Aboriginal – attending an event of cultural or spiritual significance to Aboriginals.

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, kinship, 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

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, in accordance with 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.

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.

Indigenous mental health practitioners and traditional healers

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 profession or practice other than as a student.

When practicable and appropriate, involve collaboration with health workers and traditional healers from their communities.

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.

Duty to provide indigenous interpreters

To the extent practicable and appropriate in the circumstances.

Any court, tribunal, or person exercising a power under this Act in relation to a person must ensure a Māori interpreter if it is the person’s first/ preferred language.

Other references to indigenous persons or culture

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 background). The same applies to Mental Health Review Tribunals.

An Aboriginal person is a person who satisfies all of the following requirements: Aboriginal ancestry, self-identification 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 consultation 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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N/A Not applicable.

ACT: Mental Health Act 2015

NSW: Mental Health Act 2007

NT: Mental Health and Related Services Act 1998

QLD: Mental Health Act 2009

SA: Mental Health Act 2013

TAS: Mental Health Act

VIC: Mental Health Act 2014

WA: Mental Health Act 2014

NZ: Mental Health Act (Compulsory Assessment and Treatment Act) 1992

Mental Health Acts: Community, culture and spiritual beliefs

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

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<th>Other stages</th>
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<tbody>
<tr>
<td>ACT</td>
<td>CA s31SD (2); MHA s94 (1) (g)</td>
<td>CA s31SD (2)</td>
<td>CA s31SB (2),s319 (2) (b),s323, s324, s328 (3),s329 (b),s334 (1), s335 (2)</td>
<td>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 s84, 101 and 108.</td>
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<td>NSW</td>
<td>MHFPA s14 (b) (ii)</td>
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<td>MHFPA s17 (3)</td>
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<td>QLD</td>
<td>N/A</td>
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<td>CCA ss43(2) (a), 43X (2) (a) or (3), 412A (3)</td>
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### At what stage in the criminal justice process does the term apply?**

- **Bail**: Mental Health Act 2015 (ACT) (MHA) s127 defines a forensic patient as a person in relation to whom a forensic mental health order may be made if it 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 s101 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 ‘determined’ – a term defined by the Corrections Management Act 2007 (ACT) s6.

- **Remand at a hospital or secure mental health facility**: 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 (SA) Part 8A. All the jurisdictions create a framework for detaining forensic patients. Where is the term defined? Bail

- **Custody after a determination that the accused will be fit to plead within 12 months**: 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 Criminal Law (Mentally Impaired Accused) Act 1996 (WA) (CLA) s23 defines a mental health 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 2005 (IDCCR).

- **Custody or supervised release after being found not guilty by reason of mental illness or unfit to stand trial within 12 months**: Mental Health (Compulsory Assessment and Treatment) Act 1992 (NSW) (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 2005 (IDCCR). 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 court martial: AFDA s191 (3) (a). A special care recipient may become a special patient if they appear to have developed a mental disorder: IDCCR s136 (5) (a).

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**Comment**: The definition of ‘forensic patient’ (or an equivalent term) is found in legislation from the Commonwealth of Australia or South Australia. The term ‘forensic patient’ is used in this context to refer to people who are detained in a hospital under a forensic mental health order. The definition of ‘forensic patient’ may vary depending on the Act and jurisdiction. For example, in New South Wales, the definition includes people who are required by a court to submit to the jurisdiction of the ACAT under the Crimes Act 1900 (NSW) (CA) Part 13, and people who are ‘determined’ – a term defined by the Corrections Management Act 2007 (NSW) s6.

**Other stages**: The remaining orders are made by the Mental Health Court under the Criminal Law Consolidation Act 1935 (SA) Part 8A. All the jurisdictions create a framework for detaining forensic patients. Where is the term defined? Bail

**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: s42A (1).

**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 Law (Mentally Impaired Accused) Act 1996 (Qld) (CLA) s23 defines a mental health 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 2005 (IDCCR).

**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 1997 (Tas) (CA) Part 13, and people who are ‘detained’ – a term defined by the Corrections Management Act 2007 (Tas) s6.

**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 (CYMUA) and the Crimes Act 1914 (CJA) (CA).

**The Mental Health Act 2015 (SA) (MHA) s127 defines a forensic patient 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: s42A (1).

**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 uncharged 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.

**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 uncharged 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.**