



DISCUSSION PAPER

The review

of the

**ACT Mental Health
(Treatment and Care)
Act 1994**

August 2006

Foreword

The purpose of the Review of the *Mental Health (Treatment and Care) Act 1994* (the Act) is to ensure the Act reflects best practice in mental health law, as it has developed over the last 10 years. The introduction of the *ACT Human Rights Act 2004* (the HR Act), and the required review for compatibility with the HR Act, provides an appropriate context in which the Review will be carried out.

The Discussion Paper for the Review of the *ACT Mental Health (Treatment and Care) Act 1994* aims to summarise the principles and issues to be addressed during the Review. Katy Gallagher MLA, the ACT Minister for Health, has endorsed this Paper for distribution.

The Review Policy Management Team will oversight the Review process, and consist of diverse Government membership to facilitate Government processes and engagement. Other relevant stakeholders will be engaged via the Review Advisory Committee who will review written submissions, debate issues and make recommendations to the Government. The general community will be engaged via multiple public forums and written feedback.

A consultation plan outlining the process intended to engage the community and relevant stakeholders is included in the Discussion Paper.

Comments on the Mental Health Act Review Discussion Paper will be received until Monday, 30 October 2006.

To submit your comments please fill out the Feedback Form and return it to:

Mental Health Act Review
Mental Health Policy Unit
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GPO Box 825,
Canberra City, 2601

Or email to: Russell.Killick@act.gov.au

Consultation Plan

1. Establish the Review Policy Management Team, the team will have overarching responsibilities for managing the Review Project and providing advice to Government.
2. The Review Policy Management Team prepares draft consultation plan and scoping paper, and circulates both papers to key stakeholders.
3. Invite government agencies, statutory office holders, carer, consumer and community service organisations peak bodies to nominate representatives for Review Advisory Committee and specific Issue Working Groups.
4. Release of the Discussion Paper for community consultation. Discussion paper in public circulation for 8 weeks.
5. *Discussion Paper* - Public and stakeholder consultations managed by external consultant. (6 weeks)
 - a. Consultant develops Summary paper from consultations. (1 week)
6. Options paper referred to Review Advisory Committee and Working Groups for further development and clarification of specific issues & development of a preferred Options paper. (4 weeks)
7. Release of draft for Public and stakeholder consultations managed by external consultant. (6 weeks)
 - a. Consultant develops Summary paper from consultations. (1 week)
8. Drafting Instructions Options paper referred to Review Advisory Committee and Working Groups for further development and clarification of specific issues & development of a preferred position paper. (4 weeks)
9. Position paper reviewed by Policy Management Team and Exposure Draft developed and released for consultation with the community. (14 weeks)
10. *Exposure Draft Stage 1* - Public and stakeholder consultations on Exposure Draft managed by external consultant. (6 weeks)
 - a. Consultant develops proposed amendments paper from consultations. (2 weeks)
11. Review Advisory Committee review and recommendations forwarded to the Policy Management Team. Amendments made to the Exposure Draft. (22 weeks)
12. *Exposure Draft Stage 2* - Public and stakeholder consultations on Exposure Draft managed by external consultant. (6 weeks)
 - a. Consultant develops proposed amendments paper from consultations. (1 Week)
13. Review Advisory Committee review and recommendations forwarded to the Policy Management Team. Development of a Draft Final Amendment Bill. (22 weeks)
14. Final draft amendment Bill presented to Cabinet with request for Government to table final draft of Amendment bill in Legislative Assembly. (6 weeks)

(Total Process duration is 124 Weeks includes time for two Christmas / New Year periods)

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1 Introduction

Mental health legislation is a key vehicle used by governments to ensure that people with mental illness and other mental disorders receive treatment and care. Mental Health Acts seek to establish a legal framework for the best possible care and treatment delivered in a manner that minimises restrictions of liberty and interference with a person's rights and freedoms. For many people mental health law does not impinge directly on their lives and many remain unaware of its existence or purpose. For others, mental health law can impact dramatically on their lives. An Individual's experience of mental health problems can include distress, fear, a loss of control of thoughts and actions, as well as impairment to social, recreational and occupational functioning. It is similarly distressing for families as they watch a loved one change and be over run by an illness they may know little about. Distress and concern is heightened by the possibility of harm or risk to the person or to others. A central purpose of mental health legislation is to ensure that assessment, treatment and care is available at the earliest possible point to address situations as described above as well as a range of other situations.

In 1994 the ACT Legislative Assembly passed the current *Mental Health (Treatment and Care) Act* (the Act). The 1994 Act replaced the *Mental Health Act* 1983, which predated ACT self-government. The Act was reviewed in 1997 amendments added in 1999 and more recently in 2005. The 1999 amendments introduced the care coordinator and involuntary community care orders for people with mental dysfunction whilst last the 2005 amendments concerned the administration of electroconvulsive therapy (ECT). While the Act has had other minor amendments there has not been a systematic review of the entire Act since 1994.

In the years since the Act was passed there have been significant changes in consumer and carer advocacy for appropriate legislative and service frameworks, other ACT legislation and the way mental health services are organised. The current review provides the ACT government and community the opportunity to consider amendments that will make the Act more effective and responsive to the current needs of mental health stakeholders and the community.

1.1 Overview of the Review Process

ACT Health and the Department of Justice and Community Safety are overseeing the Review through the Review Policy Management Team and released a brief Scoping Paper for initial comment late 2005 (Appendix A). The Review, scheduled for a two year period, will comprise the following three major stages of broad and comprehensive community consultations.

- Stage One, Consultation on The Consultation Plan and Consultation Discussion Paper
- Stage Two, Consultation on the new Act – Exposure Draft 1
- Stage Three, Consultation on the new Act – Exposure Draft 2

The Review Policy Management Team will be assisted by a Review Advisory Group comprising representatives of consumer, carers and community service organisations, peak bodies, government agencies and statutory officer holders. Specific Issue Working Groups will be established on a needs basis as the Review progresses. The Review Policy Management Team will engage an external consultant who will assist with the coordination and conduct of the Review.

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1.2 Overview of the Discussion Paper

This Discussion Paper will be used to facilitate broad community consultation and input during Stage One of the Review. The Discussion Paper is divided into the following sections

- The Current Policy And Social Context (2)
- The Act's Framework (3)
- Capacity, Competence And The Non-Protesting Patient (4)
- Voluntary Treatment (5)
- Involuntary Admission, Treatment And Care (6)
- Treatment (7)
- Disclosure Of Information (8)
- Children And Young People (9)
- Forensic Patient And Others Subject To The Criminal Justice System (10)
- Oversight And Protection Bodies (11)

Questions are progressively posed throughout the Discussion Paper. A form to provide feedback on the Discussion Paper and input to the Review is provided in Appendix One.

2 Current Policy and Social Context

Since the Act was passed in 1994 there have been significant developments in mental health policy at both the national and territory levels. This has been stimulated through the National Mental Health Strategy. Mental health services are under increasing scrutiny and are the subject of national, local parliamentary, and mental health sector inquiries. In 2005 the Commonwealth Human Rights and Equal Opportunities Commission and the Mental Health Council of Australia released the joint *Not for Service Report*.¹ This report was critical of the services provided in Australia to persons with mental health problems.

During 2005 the Australian Senate undertook an Inquiry into mental health in Australia. The Senate Inquiry released a first report on 30 March 2006 and a final report on 28 April 2006 including a range of recommendations. The ACT Legislative Assembly Standing Committee is currently undertaking an inquiry into 'the current levels of access to safe, secure and affordable housing for people with mental illness.'

While mental health services are under increased scrutiny, the legislative environment affecting mental health services has also changed. This includes the introduction of *ACT Human Rights Act* in 2004 and the ACT Government's commitment to building an ACT Prison. Since the last review of the Act, mental health consumers and carers have raised issues which contributed to the impetus to review the Act. Issues include consumer advanced agreements, carers rights, and the oversighting structure.

¹ *Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia*, Mental Health Council of Australia, Canberra, 2005

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2.1 *National Developments*

This section outlines recent and relevant developments in mental health services and policy both throughout Australia and in the ACT.

2.1.1 National Mental Health Strategy

The ACT Government participated in all three National Mental Health Plans to date, the first 1993-98, the second 1998-2003 and the third and current plan 2003-2008. The National Mental Health Strategy provided an agreed framework for the improvement of mental health care in all Australian States and Territories. Important documents arising from the Plans have helped to guide reform and development.²

The renewed Plan increased the focus on increasing the responsiveness to consumers and carers across all mental health and related services and improving community partnerships to assist with the recovery of people experiencing mental illness and mental health problems. The ACT Government, along with other States and Territories, reports annually on the progress made toward the implementation of agreed objectives and benchmarks through the National Mental Health Report.³

2.1.2 National and International Standards, Principles and Focus on Mental Health Legislation

The National Mental Health Plans have sought to enshrine in Australian mental health care and policy the *United Nations Principles for the Protection of Persons With Mental Illness and for the Improvement of Mental Health Care*.⁴ In 1992, all Australian State and Territory governments as well as the Commonwealth Government, agreed to develop legislation by 1998 consistent with the UN Mental Health Principles. Under the National Mental Health Strategy, Model Mental Health Legislation containing model clauses reflecting the UN Principles and the National Mental Health Statement of Rights and Responsibilities was prepared in 1994 as a guide.⁵ In 1996 a Rights Analysis Instrument was prepared to assist Australian governments to measure their progress toward implementing legislation consistent with accepted Rights Instruments.⁶

² Australian Health Ministers, *National Mental Health Plan*, Australian Government Publishing Service, Canberra 1992; Australian Health Ministers, *National Mental Health Plan 2003-2008*, Australian Government, Canberra 2003; Australian Health Ministers, *Mental Health Statement of Rights and Responsibilities*, Australian Government Publishing Service, Canberra 1992; AHMAC National Mental Health Working Group, *National Standards for Mental Health Services*, Commonwealth Department of Health and Family Services, Canberra 1997; AHMAC National Mental Health Working Group, *Mental Health Promotion and Prevention National Action Plan*, Commonwealth Department of Health and Family Services, Canberra 1999

³ See for example: Commonwealth Department of Health and Ageing, *National Mental Health Report 2002: Seventh Report Changes in Australia's Mental Health Services in Australia under the First Two Years of the Second National Mental Health Plan 1998-2000*, Commonwealth of Australia, Canberra 2002

⁴ United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, 46/119 17 Dec 1991: <http://www.unhchr.ch/html/menu3/6/68.htm>

⁵ Rees, N, Craze, L & K. Ross, *Model Mental Health Legislation: Report to the Australian Health Ministers' Advisory Council National Working Group on Mental Health*, University of Newcastle, Centre for Health Law, Ethics and Policy, 1994, Vols 1 & 2

⁶ Australian Health Ministers' Advisory Council National Working Group on Mental Health, *Rights Analysis Instrument*, Commonwealth Department of Health and Family Services, Canberra 1997

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In recent years, the World Health Organisation has urged governments to consider the role mental health legislation can play in areas critical to recovery in the community.⁷ Recently in Australia, the Human Rights and Equal Opportunity Commission's and the Mental Health Council of Australia's Report, *Not for Service* argued there is still need for improvement in mental health legislation.

2.2 *Developments in the ACT*

2.2.1 ACT Human Rights Act 2004

In 2004 The Legislative Assembly passed the ACT *Human Rights Act* (HRA 2004). There is a requirement that all relevant ACT legislation is reviewed for compatibility with this Act. Mental health legislation necessarily includes powers to place significant restrictions on the rights and personal liberties of patients, in particular the freedom to refuse care and treatment. A diagnosis of mental disorder alone would never be sufficient to justify use of compulsory powers. The review will seek feedback on the current Act's restrictions on the rights of those coming under its provisions.

2.2.2 ACT Government - Social and Living Circumstances of People Experiencing Mental Illness and their Families and Carers

The ACT *Mental Health Strategy and Action Plan*⁸ makes clear the Government's commitment to improving the social and living circumstances of people experiencing mental health problems as well as those of their families and carers. The current Review will consider whether modern mental health legislation is able, as WHO suggests, to provide instructions for the guarantee of services including support for people coming under its provisions.⁹

2.2.3 ACT Government - Commitment to Carers

In August 2004, the ACT Government launched *Caring for Carers in the ACT* - a plan for action 2004-2007 (The Action Plan).¹⁰ This plan outlines 34 actions to be progressed by the ACT Government over three years in order to achieve the objectives of the Caring for Carers Policy. A commitment of the Action Plan was to review the current legislative position of carers in the ACT and identify areas for legislative reform, with a view to amending existing ACT legislation or creating a Carers Act. The Review of the *Mental Health (Treatment and Care) Act* will invite comment on whether special provisions are required in relation to carers.

⁷ World Health Organization Europe, *Mental Health Legislation. Briefing paper. WHO European Ministerial Conference on Mental Health: Facing the Challenges, building solutions*, WHO, 2004, p2. EUR/04/5047810/B1 Available at: <http://www.euro.who.int/document/mnh/ebrief01.pdf>. & World Health Organisation, Green Paper: Improving The Mental Health of the Population: Towards a strategy on mental health for the European Union, European Communities, The Hague, 2004, p. 12: http://europa.eu.int/comm/dgs/health_consumer/index_en.htm

⁸ ACT Health, *ACT Mental Health Strategy and Action Plan 2003-2008*, ACT Government, Canberra 2003

⁹ World Health Organisation, *The Resource Book on Mental Health, Human Rights and Legislation*, Department of Mental Health and Substance Abuse, WHO. 2005, pp. 6

¹⁰ ACT Health, *Caring for Carers in the ACT: A plan for action 2004-2007*, ACT Government, Canberra 2004

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2.2.4 ACT Government - Commitment to Building an ACT Prison

A high proportion of persons remanded in custody and sentenced to imprisonment are suffering from mental health problems requiring clinical or other professional intervention. The ACT Government is soon to build a correctional centre in the ACT which will be known as the Alexander Maconochie Centre.¹¹ The operating philosophy will be the major factor influencing the design of the Centre. Individual programs and activities for prisoners will be based on individual assessment and on a Throughcare approach focusing on providing:

- An appropriate continuum of health care, in particular addressing substance abuse and mental health issues
- Individual Case and Sentence Plans based on individual prisoners' needs and presenting risk factors
- Common prisoner and offender programs based on assessment of risk and need and a menu of programs targeting those attitudes and behaviours linked to the risks of re-offending
- Opportunities for self-development, improved quality of life and social integration
- Linkages with community based programs and services
- Support for re-settlement
- The engagement of family and the community in the prisoner's correctional experience. (pp.5-6)

The needs of those with mental health needs, women, indigenous prisoners and short-term offenders will be specifically targeted.

The current Mental Health Act enables the courts to divert mentally ill people to the health and community care systems for assessment and assistance. The Review will consider how to ensure that people detained in the new prison receive mental health treatment and care at the earliest possible point whilst also ensuring community safety. Enabling provisions facilitating local treatment care and supervision of forensic mental health patients (where possible) will also require consideration.

2.3 *Developments in Mental Health Services, Treatment and Care*

Since the introduction of the current Act there has been an increased reliance on treatment and care in the community. With this has come a greater reliance on the role of families and carers. ACT Health's new mental health model of care formalises new policy, service emphasis and directions which have arisen in recent years. These include prevention, promotion and early intervention, care planning, relapse and crisis prevention and recovery. The Review of the Act will consider whether and how the new legislation should reflect and support these new developments and emphases.

¹¹ ACT Prison Project, *Alexander Maconochie Centre: Functional Brief*, ACT Corrective Services, Department of Justice & Community Safety, Canberra 2005

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2.4 Changing Views and Priorities of Consumers and Carers

The views and priorities of consumers and carers have also been changing in recent years. Consumers in a number of states and territories have voiced concern that mental health legislation should address a number of vital matters including:

- Consumer participation in treatment and care planning
- A definition of ‘treatment’ which promotes more holistic and comprehensive treatment and care
- Discharge planning and a requirement for services to be offered and provided
- Advanced directives also known as Ulysses Agreements
- Intervention prior to a crisis and at the earliest possible stage
- Greater capacity to seek voluntary admission, assessment, treatment and care before deterioration is significant
- Restriction of the role of police in apprehension and transportation and confirmation of the role of ambulance officers and mental health officers etc.

Families and carers have raised a similar set of concerns. Additionally they have urged government to consider a number of further issues including:

- Recognition of role of families and carers at key points
- The need to administer the Act’s provisions whilst minimising damage to family relationships
- The right of families to be informed, consulted and involved

The current Review will seek the views of consumers and carers about these matters amongst other things.

2.5 A Shared Concern

Many in the community, including consumers and carers, share a concern about people with mental health issues who exhibit disturbing behaviour that might ultimately lead to a minor offence, continuing to cycle through the criminal justice system. Some individuals are unwell and are engaging in low level offending behaviour, are not suitable for admission to the PSU, and yet the behaviour may warrant a discretion by police not to charge the person. The continuing behaviour may reach the point where the police decide to charge the person and the Courts then face the dilemma of dealing with an unwell person in the criminal justice system.

The review seeks discussion of how this cycle of low level anti social behaviour and involvement with the police might be ameliorated or prevented.

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3 The Framework of the Act

The objects and principles of a piece of legislation are important because they provide insight into the intentions of the legislature i.e. of the ACT Legislative Assembly. Objects and principles, though they do not give legally enforceable rights, they assist with the interpretation and implementation of the Act. The statements may also assist policy and services operating under the legislation to progressively implement better standards of care, treatment, protection and practice.

The Review of the Act provides an opportunity for the Government and Legislative Assembly to reaffirm its commitment to mental health treatment and care. Other jurisdictions when recently rewriting their mental health laws have taken the opportunity to incorporate into the objects and principles, new policy emphases including family and carers¹², people subject to the criminal justice system and human rights instruments¹³.

Section 9 of the current Act provides for the maintenance of freedom, dignity and self-respect and states that any restrictions are kept to ‘minimum necessary for the proper care and protection of the person and the protection of the public’. Recent reviews of mental health law elsewhere have invited comment on underpinning principles. Recently, some jurisdictions acting on community feedback have introduced a comprehensive framework of principles to guide the operation of their mental health laws (eg QLD, NT and Scotland).¹⁴

4 Capacity and Competence and the ‘Non-Protesting’ Patient’

4.1 *What are the Issues?*

The World Health Organisation recently referred to the tendency to use the terms ‘capacity’ and ‘competence’ interchangeably in relation to mental health. However, and as the WHO notes, they are not the same. Generally, ‘capacity’ refers specifically to the presence of mental abilities to make decisions or to engage in a course of action, while ‘competence’ refers to the legal consequences of not having the mental capacity. Hence ‘capacity’ is a health concept, whilst ‘competence’ is a legal concept. Capacity refers to individual levels of functioning, and competence to the impact of such on legal and social standing. For example, a person may lack mental capacity due to a serious mental disorder, and this may result in being found not competent to make financial decisions.¹⁵

Determination of *incapacity* may be made by a health professional, but a specially established statutory or judicial body would determine *incompetence*. Capacity is the test for competence, and people should be judged as lacking competence only if they are actually incapable of making specific kinds of decisions at a specific time.

The ‘non-protesting’ patients are people with mental disorders who are unable to give consent but do not refuse admission/treatment. The purpose of mental health legislative provisions is to provide ‘non-protesting’ patients with safeguards, while at the same time providing

¹² S5(c) WA *Mental Health Act 1996*

¹³ Ss3 (b)&(t) NT *Mental Health & Related Services Act 1999*

¹⁴ See for example s8 Queensland *Mental Health Act 2000*, ss1-3 Scotland *Mental Health (Care & Treatment) Act 2003*, s12 NT *Mental Health & Related Services Act 1999*

¹⁵ *The Resource Book on Mental Health, Human Rights and Legislation*, Department of Mental Health and Substance Abuse, World Health Organization. 2005, pp. 40 - 45.

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necessary admission and treatment to people *unable to give informed consent*. People who are not resisting treatment are not incorrectly made either involuntary or voluntary patients; however if users object to their admission or treatment they must immediately stop being regarded as ‘non-protesting’ and the full criteria for determining involuntary admission and treatment must be applied.

The current ACT *Mental Health (Treatment and Care) Act* requires in sections 26, 54 & 55 the Tribunal to determine whether the person ‘consents’, ‘refuses to consent’ or has the ‘capacity to consent’. The Act defines informed consent but does not provide guidance on the definition or determination of capacity to consent.

4.2 Provisions Elsewhere

The Model Mental Health Legislation (1994:60) suggested that in order for someone to be considered capable of giving informed consent, a person must be capable of understanding the elements of informed consent, capable of understanding the effects of giving consent and able to communicate to the person responsible for the treatment his or her decision to consent or refuse it. The mental health laws of Queensland and Western Australia take a similar approach.

Questions

1. *How should the new Act approach the issues of ‘capacity’, ‘competence’ and the ‘non-protesting’ patient?*

5 Voluntary Treatment

Being able to seek voluntary treatment enables a person with mental illness to obtain mental health assessment, treatment and care at an early stage when they first begin to notice warning signs or symptoms for their relapse signature. Expressed provisions enable a person to seek assistance whilst he or she still has sufficient insight.

The UN Principle (15.1) states that ‘voluntary treatment is to be the preferred form of hospital treatment of people with mental illness’ and Principle 15.2 states that ‘voluntary access to a mental health facility must be administered in the same way as access to any other health care facility’. This second principle led to debate in Australia as to whether it is appropriate to have provisions in mental health law for voluntary admission or whether by doing so, this would stigmatise those so admitted. The Model Mental Health Legislation team considered this question at length. They explained the debate:

It has been argued by some people that provisions which deal with voluntary patients stigmatise them and are inconsistent with the policy of mainstreaming mental health services. An opposing argument is that it is important to encourage voluntary admission to a mental health facility for treatment and that it best done by expressly dealing with voluntary admission in mental health legislation and by surrounding voluntary patients with an appropriate package of legal rights¹⁶

The Model Mental Health Legislation Team decided in favour of including provisions for voluntary admissions – for adults and for young people aged 14-18. NSW and the NT have similar provisions to those suggested. For example, the NSW Act enables a person to be admitted voluntarily on an oral or written application by the person to the medical superintendent.¹⁷ The NT Act requires a person to be given reasons both orally and in writing if they are refused voluntary admission. The NT Act also provides for a person to appeal against refused admission.¹⁸

The current Act in the ACT does not contain provisions for admission as a voluntary patient but does contain provisions for a person to make an application for their own involuntary treatment. Despite the lack of express provisions, people are admitted on a voluntary basis to mental health facilities in the ACT. Evidence discussed in the ACT component of the *Not for Service Report* suggests people can encounter difficulty in obtaining voluntary admission.¹⁹ Whilst there are likely to be several reasons for this, discussion could usefully consider whether expressed legislative provisions would assist access.

Questions

2. *Are provisions for voluntary admission, treatment and care required in the ACT Mental Health Act?*
3. *Would voluntary admissions provisions in mental health law assist a person to obtain assessment and treatment at an early stage of becoming unwell or of relapse?*

¹⁶ Rees, N, Craze, L & K. Ross, *Model Mental Health Legislation: Report to the Australian Health Ministers' Advisory Council National Working Group on Mental Health*, University of Newcastle, Centre for Health Law, Ethics and Policy, 1994, Vol 1, p. 45

¹⁷ S12(1) NSW *Mental Health Act* 1990

¹⁸ Part 5 NT *Mental Health & Related Services Act* 1999

¹⁹ *Not for Service: Experiences of Injustice and Despair in Mental Health Care in Australia: Summary*, Mental Health Council of Australia, Canberra, 2005. p. 78

6 Involuntary Admission, Treatment, Care and Review

The current ACT Act enables involuntary admission, treatment and care for people with two conditions – ‘mental illness’ and ‘mental dysfunction’. The ACT is the only Australian jurisdiction with provisions for intervention against a person’s will on the basis on ‘mental dysfunction’. This section outlines the current definitions of the conditions falling under the Act’s purview, the grounds that need to be met for involuntary treatment and care to be authorised and the procedures for admission, assessment, review and appeal. Relevant provisions elsewhere are discussed and questions raised.

6.1 Definitions

How a mental health statute defines mental illness and other conditions coming under its control, can be a source of confusion. The most common misunderstanding relates to the difficulty in understanding that the definitions in legislation are not definitions of the condition per se, but are definitions for the *purposes* of the Act alone. This means that the definition of mental illness used by a mental health statute applies or is to be used only when employing the criteria for involuntary intervention on the grounds of mental illness. The definition used does not seek to define mental illness for all purposes. It simply means, this is how the law defines ‘mental illness’ for situations requiring action to be taken against a person’s will or without a person’s consent. The two definitions in the ACT Act, ‘mental illness’ and ‘mental dysfunction’, are outlined and discussed below.

6.1.1 ‘Mental illness’ for the Purpose of Involuntary, Admission, Treatment and Care

The definition of mental illness contained in the ACT Act is to be used only when employing the criteria for involuntary treatment and care in hospital on the grounds of mental illness, for involuntary treatment in the community and for the admission and treatment of forensic patients and offenders. UN Principle 4.1 provides that:

‘a determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards.’ A key task then, is for mental health legislation to give ‘medical’ meaning to the term ‘mental illness’

Any decision that a person has a ‘mental illness’ for the purposes of mental health legislation must be made in accordance with internationally accepted medical standards. This requirement minimises the risk of a non-clinical interpretation of mental illness, whilst not restricting access to treatment for those people who require it.

In the Dictionary of terms found within the Act, the ACT Act states that:

***mental illness** means a condition that seriously impairs (either temporarily or permanently) the mental functioning of a person and is characterised by the presence in the person of any of the following symptoms:*

(a) delusions;

(b) hallucinations;

(c) serious disorder of thought form;

(d) a severe disturbance of mood;

(e) or sustained or repeated irrational behaviour indicating the presence of the symptoms referred to in paragraph (a), (b), (c) or (d).

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This definition is either the same or almost the same as the definition proposed by the Model Mental Health Legislation and definitions for mental illness used in the NSW, WA, NT, Victorian and Queensland Acts. Some Acts emphasise the *medical nature* of ‘mental illness’ with a view to also emphasising the Act’s primarily therapeutic and health-based purposes. The Northern Territory Act adds the requirement that determination of a person having a mental illness is made in accordance with internationally accepted clinical standards and concordant with the current edition of the World Health Organisation, International Classification of Mental and Behavioural Disorders, Clinical Description and Diagnostic Guidelines or the American Psychiatric Diagnostic and Statistical Manual of Mental Disorders (s6(2)).

Questions

4. *Does the Act’s current definition of mental illness serve ACT requirements?*
5. *Does the Act’s definition of mental illness require any change?*

6.1.2 ‘Mental Dysfunction’ for the Purpose of Involuntary Admission, Treatment and Care

The ACT Act provides for involuntary admission, treatment and care of people with ‘mental dysfunction’ which is defined in the ACT’ as:

***mental dysfunction** means a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion.*

This definition is broad and encompasses non-medical conditions. Commentators have discussed the implications of involuntarily detaining people with non-medical conditions through provisions in mental health legislation.²⁰ If the ACT Legislative Assembly is of the view that given local circumstances and contingencies there is a need for people who could be considered to have ‘mental dysfunction’ to be provided with care and control against their will, the question becomes whether the Mental Health Act given general international agreement about the parameters of its purposes, is the right piece of legislation for this to occur under.²¹

Questions

6. *Are provisions for ‘mental dysfunction’ required in the ACT? If so, is the Mental Health Act, the right place for these provisions?*
7. *Are any changes required to the Act’s provisions for ‘mental dysfunction’?*

²⁰ See for example, Watchirs, H, ‘Human Rights audit of mental health legislation – results of an Australian pilot’, *International Journal of Law and Psychiatry*, 2005: 28(2), pp 99-125.

²¹ The ‘mental dysfunction’ provisions though different are not dissimilar to aspects of the UK mental disorder guardianship provisions – ss 7-8 UK *Mental Health Act 1983*

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6.1.3 Exclusions

Mental health statutes throughout the world seek to clarify the grounds as to when a person is not considered to have a mental illness by reason of that matter alone. These grounds or matters are referred to as 'exclusions'. The current ACT Act provides no exclusionary clauses for people determined to have a 'mental illness' for the purposes of the Act, but provides exclusions for people determined to have a 'mental dysfunction'. People are not to be considered to have a 'mental dysfunction' by reason alone of factors including political belief, religious beliefs, sexual preference, involvement in criminal activity or in activities viewed as 'immoral', drug or alcohol taking or engagement in anti-social behaviour.

These exclusions are similar to those found in other Australian mental health Acts (eg NSW, NT, QLD). The exclusionary matters are drawn largely and directly from the UN Principles. Exclusions found elsewhere include involvement in family conflicts²² and having been previously treated for mental illness.²³ Both the NSW and Victorian Acts add a clarification in relation to people who are drug or alcohol affected. For example, section 8(3) of the *Victorian Mental Health Act 1986* states that the exclusion that the person takes drugs or alcohol does not prevent the serious temporary or permanent physiological, biochemical or psychological effects of drug or alcohol taking from being regarded as an indication that person is mentally ill. The QLD Act also seeks to clarify the Act's intention by giving examples –

A person may have a mental illness caused by taking drugs or alcohol.

A person may have a mental illness as well as an intellectual disability.

Providing an explanatory statement that a person with personality disorder may also have a mental illness might assist to clarify the situation for a group of people who are currently thought to be denied assessment and treatment because of their primary diagnosis.

Questions

8. *Should the exclusionary clauses be extended to also apply to people determined to have a mental illness for the purpose of the Act?*
9. *Are any further exclusionary or clarifying clauses required?*

6.1.4 Addressing the Needs of People with Personality Disorder and Other Mental Disturbances

The effect of exclusionary clauses in the UN Principles and Australian mental health statutes results in people with a disorder of personality *alone* not being determined to be 'mentally ill' for the purposes of involuntary treatment and care. In Australia, this does not mean that people with personality disorder cannot also experience mental illness that can result in them being involuntarily detained and treated as a 'mentally ill' person. The United Kingdom has taken a different approach and section 3 of the UK *Mental Health Act 1983* includes psychopathic disorder in the definition of the conditions coming under the provisions of the Act.

²² 12(j) QLD *Mental Health Act 2000*

²³ s12(k) QLD *Mental Health Act 2000*

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In the ACT there is concern among consumers and carers that a primary diagnosis of personality disorder is currently preventing a person who is in crisis and deteriorating from being assessed and considered for treatment under the Act. The Review is seeking to explore options for ensuring that a person who is experiencing mental illness irrespective of their primary diagnosis has the same rights to assessment and treatment as other members of the community.

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The Model Mental Health Legislation suggested that provision be made for a person with a personality disorder alone or with other mental disturbances to be involuntarily admitted for a brief period of up to 10 days to a mental health facility on the grounds of 'mental disorder'. Both the NSW & NT mental health acts have similar provisions for brief detention to those suggested by the Model Legislation. These provisions enable a person who does not fulfil the criteria for involuntary admission on the grounds of mental illness but whose behaviour is so irrational or disturbed as to lead to the conclusion that the person is experiencing a severe impairment of a nature requiring psychiatric assessment, treatment or therapeutic care to prevent further serious mental or physical deterioration.

The reason for the short-term detention is to permit medical and mental health intervention in times of crises or where a person needs assessment but it is unclear what is wrong. Mental health professionals are able to determine whether a person might have an underlying mental illness which should be treated or whether other assistance can be provided. It also assists the person to get through the crisis and to engage with mental health case-management or support services in the community. This provision seeks to strike an appropriate balance between longer term hospitalisation, which may offer little more than preventive detention and control, and not denying a person access to a mental health facility during a short-term crisis. During the Review, discussion is also required as to whether the new Act needs to make provision for assisting people with personality disorder against their will outside of a crisis situation.

Questions

- 10. How might the needs of people with personality disorder best be addressed?*
- 11. Does mental health legislation have a role in meeting those needs and should there be specific provisions for people with personality disorder? What might such provisions entail?*
- 12. Are any provisions for people with mental disturbances other than mental illness required?*

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6.2 *Involuntary Treatment and Care - 'Mental Illness' and 'Mental Dysfunction'*

6.2.1 Who Can Apply and How

Mentally dysfunctional or mentally ill persons are able to apply to the Mental Health Tribunal for an involuntary care or treatment order on their own behalf. The application must be in writing and accompanied by a statutory declaration setting out the detailed reasons for the application. Another person can make an application for an involuntary order in respect of someone they know. A referring officer from a court can make an application in respect of a person appearing before a court. Other Australian states have provisions for someone to seek psychiatric assessment against another person's will or without that person's consent. The ACT is unique in having a provision that enables a person to seek an involuntary order on their own behalf. The provision may serve a useful purpose in encouraging people to seek help for their deteriorating condition whilst they still have insight.

Questions

13. Is the provision enabling a person to seek an involuntary order on their own behalf a useful or appropriate provision?

6.2.2 Grounds for Application

Irrespective of who applies for the order, and whether the order sought is a mental health order (mental illness) or a community care order (mental dysfunction), the grounds that must be met before an application to the Tribunal can be made are:

(a) A person is unable, because of mental dysfunction or mental illness—

(i) to make reasonable judgments about matters relating to his or her health or safety; or

(ii) to do anything necessary for his or her health or safety;

and, as a result, the person's health or safety is, or is likely to be, substantially at risk; or

(b) is or is likely, because of mental dysfunction or mental illness, to do serious harm to others (s14(1)).

The application is made on reasonable grounds and relies on ordinary community understanding of mental illness and mental dysfunction. The Review seeks comments on these grounds.

Questions

14. Are the grounds required for an application appropriate?

15. Are the grounds too narrow or alternatively are they too broad?

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6.2.3 Emergency Assessment, Detention and Care

Under the current Act the Tribunal, a police officer and a doctor or mental health officer can initiate emergency assessment, detention and care. Before apprehending a person, a police officer has to believe on reasonable grounds that a person is mentally ill or mentally dysfunctional and has attempted or is likely to attempt to commit suicide or to inflict serious harm on himself or herself or another person (s37(1)). Except for the inclusion of mental dysfunction, this provision is consistent with the suggestions of the Model Mental Health Legislation and other Australian statutes. The grounds are prescribed to minimise undue police intervention.

The grounds for police intervention are different from those of intervention by mental health officer or a doctor. A mental health officer or doctor is expected to act in accord with medical standards and exercise clinical judgment. Section 37(2) states that where a doctor or mental health officer believes on reasonable grounds that:

- (a) a person is mentally dysfunctional or mentally ill and—*
 - (i) as a consequence, requires immediate treatment or care; or*
 - (ii) in the opinion of the doctor or mental health officer, the person's condition will deteriorate within 3 days to such an extent that the person would require immediate treatment or care;*
- (b) the person has refused to receive that treatment or care; and*
- (c) detention is necessary for the person's own health or safety, social or financial wellbeing, or for the protection of members of the public; and*
- (d) adequate treatment or care cannot be provided in a less restrictive environment; the doctor or mental health officer may apprehend the person and take him or her to an approved health facility.*

Once admitted, the Act sets out a detailed process for assessment, discharge or application to the Tribunal for an Involuntary Order. A doctor can authorise detention for 3 days after which review by the Tribunal is required. This process and the time before a review is required differs throughout Australia from up to 42 days in South Australia, 8 weeks in Victoria, 28 days in both Tasmania and Western Australia and 7 days in the Northern Territory. In Queensland an initial authorisation is made by a medical practitioner or an authorised mental health practitioner for 7 days after which an involuntary treatment plan may be an outcome with the Mental Health Review Tribunal reviewing within 6 weeks.

The ACT provisions are similar to those of Model Mental Health Legislation the NT and NSW, but different from the remaining states where medical practitioners and psychiatrists can authorise detention and treatment for a longer period before external review is required.

Questions

- 16. Are any changes required to the Act's provisions for emergency assessment, detention and care?*
- 17. What changes or new provisions might usefully be considered?*

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6.2.4 Role of Mental Health Practitioners, Ambulance and Police Officers

As discussed above the current Act has detailed provisions concerning the powers and roles of doctors, mental health practitioners and police officers. Consumers and carers and the police themselves, have in recent years argued for reducing the role of police officers and for clarification of when and under what circumstances their services may or may not be required.

The Model Mental Health Legislation suggests that police should only be used if there is no other alternative and if the threat posed by the person warrants police involvement. Queensland and the Northern Territory have recently introduced provisions empowering ambulance officers to intervene and transport a person for the purposes of assessment. NSW is currently considering introducing similar provisions whilst South Australia is considering introducing provisions which clarify the roles and powers of security staff at emergency departments.

Questions

18. Should the Act seek to expand or reduce the requirement for police intervention?

19. Should the Act make provisions for the involvement of ambulance officers in the apprehension and transporting to hospital of a person with mental illness or mental dysfunction?

6.2.5 Involuntary Orders - the Grounds for Mental Health and Community Care Orders

Grounds for a Mental Health Order

The Mental Health Tribunal can make a psychiatric treatment/mental health order for a person determined to be 'mentally ill' under the Act and a community care order for a person determined to be 'mentally dysfunctional' under the Act. The criteria for making a psychiatric treatment order are found in section 28 and are as follows:

- (a) the person has a mental illness; and*
- (b) that because of the illness, the person is likely to—*
 - (i) do serious harm to himself, herself or someone else; or*
 - (ii) suffer serious mental or physical deterioration;**unless subject to involuntary psychiatric treatment; and*
- (c) that psychiatric treatment is likely to reduce the harm or deterioration and result in an improvement in the person's psychiatric condition; and*
- (d) the treatment cannot be adequately provided in a way that would involve less restriction of the freedom of choice and movement of the person than would result from the person being an involuntary patient.*

In making a decision, section 26 of the Act requires the Tribunal to take into account a number of factors including the views and wishes of the person and the views and wishes of the people responsible for the day to day care of the person. These grounds are similar to those suggested by the Model Mental Health Legislation with the exceptions that the latter

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requires that treatment is available at the mental health facility. Different grounds from other statutes include 'health, safety and welfare of a person'²⁴, a known relapse signature or demonstrated pattern of a recurring illness²⁵ and 'self inflicted harm' including serious financial harm, lasting or irreparable harm to any important personal relationship resulting from damage to the reputation of the person among those with whom the person has relationship and serious damage to the reputation of the person.²⁶

Discussion is invited about whether the current criteria for involuntary treatment of mentally ill persons strike an appropriate balance between the community's right to be protected from harm, the right of members of the community to choose their own lifestyle when the safety of others is not threatened, and the responsibility of the community to intervene when, as a result of mental illness, a person is placed at risk and may not be able to make informed decisions.

Questions

20. *Are any changes required to the grounds for an involuntary order for a 'mentally ill' person?*
21. *Do the current grounds strike an appropriate balance between the different sets of rights and interests?*

Grounds for a Community Care Order

The Mental Health Tribunal can make a community care order for a person determined to be 'mentally dysfunctional' under the Act. The criteria for making a community care order are found in section 36 and are as follows

- (a) *the person is mentally dysfunctional; and*
- (b) *that because of the mental dysfunction, the person is likely to—*
- (i) *do serious harm to himself, herself or someone else; or*
 - (ii) *suffer serious mental or physical deterioration;*
- unless subject to involuntary treatment, care or support; and*
- (c) *that treatment, care or support is likely to reduce the harm, or the likelihood of harm, and*
- (d) *that in the circumstances, a psychiatric treatment order should not be made; and*
- (e) *the treatment, care or support cannot be adequately provided in a way that would involve less restriction of the freedom of choice and movement of the person than would result from the person being an involuntary patient.*

Discussion is invited about whether any changes are needed to the criteria for community care orders.

Questions

22. *Are any changes required to the grounds for the provision of an involuntary order for a 'mentally dysfunctional' person?*

²⁴ s 36 (5)(b)(i) Scotland *Mental Health(Care and Treatment) Act* 2003.

²⁵ S 15 (1.1)-(1.2) Canada *Mental Health Act* 1990

²⁶ S 26(2) of the WA *Mental Health Act* 1996

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6.3 Creation and Review of Mental Health and Community Care Orders

6.3.1 The Tribunal

The Mental Health Tribunal has only existed since the introduction and implementation of the Mental Health (Treatment & Care) Act. The Tribunal is a relatively new body and the Review provides a timely opportunity for discussion as to whether any fine tuning is required in relation to how the Tribunal operates including for example:

- How evidence is gathered, heard and assessed
- Parties who are given leave to appear before the Tribunal
- The effects for a person who has matters before the Tribunal as well as the Magistrates Court etc.

The Review also invites discussion as to whether any unforeseen implications have arisen from the Tribunal being under the organisational umbrella of the Magistrates Court, a body with a legal imperative. The Review invites comment as to whether any procedural issues are arising from the placement of a body having primarily a therapeutic focus within the Magistrates Court and whether jeopardy is in any way occurring when a Presiding Officer of the Tribunal is also hearing a matter in a different jurisdiction about the same person.

Questions

23. Are the Act's provisions for the membership, functions and operations of the Tribunal appropriate?

24. Are any changes or new provisions required?

6.3.2 Making a Determination -Orders which can be made by the Tribunal

As stated above the Tribunal can make two types of involuntary orders – a psychiatric treatment order and a community care order. The Tribunal can also order the discharge of a person because that person fails to meet the required criteria for either order. A psychiatric order or community care order has effect for up to 6 months.

Involuntary Psychiatric Treatment Order

Section 29 of the current Act outlines the content of a psychiatric treatment order made by the Tribunal. The order may state one or more of the following:

- the health facility to which the person is to be taken
- that the person undergo psychiatric treatment (other than ECT and psychosurgery)
- that the person undertake a counselling, training, therapeutic or rehabilitation program
- that limits be imposed on the person's communication with other people

The order might require the person to be an inpatient or allow the person to live in the community at their usual abode. Sections 30 and 31 enable the Tribunal to make a restriction order stating that the person must live, but not be detained, at a certain place or be detained at a stated place. These provisions enable the Tribunal to limit a person's freedom of movement,

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ability to choose his or her own residence, and rights of freedom of association. The restriction order has effect for a period of up to 3 months. Discussion is invited on these possible limitations.

Questions

25. Are any changes or new provisions for an involuntary psychiatric order required?

Involuntary Community Care Order

Sections 36 A-D of the ACT Act outlines the content of community care orders and restriction orders for people determined to be ‘mentally dysfunctional’ under the Act. The content of the order are similar to those of the psychiatric treatment order with the main exception being that hospitalisation in a mental health facility is not included as an option. The other main difference is that a person may be given medication by a doctor for the treatment or amelioration of the person’s mental dysfunction. A restriction order for a mentally dysfunctional person additionally includes:

- that a person can be detained at a stated community care facility
- that the person must not approach a stated person or a stated place or undertake stated activities

Questions

26. Are any changes required to the provisions for a community care order?

27. Are the provisions for restrictions on communication, activity and choice appropriate?

6.3.3 Appeal and Judicial Review

Section 141 of the current Act provides for appeals from decisions made by the Tribunal to the Supreme Court. An appeal may be brought as a right and must be brought within 28 days after the day on which the decision was made. The person making an appeal can also request a statement of reasons for the Tribunal’s decisions if this was not provided. The review seeks the views of consumers and others on the adequacy and clarity of avenues of appeal available under the Act. It might be useful to consider appeal provisions found elsewhere in Australian mental health legislation, see for example.²⁷

Questions

28. What review and appeal mechanisms should be provided?

29. What matters should be open to appeal or review?

²⁷ s127 NT Mental Health and Related Services Act 1999, s29 (1) Victorian Mental Health Act 1986, s29 (2) Victorian *Mental Health Act* 1986.

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6.3.4 Rights of Consumers and Carers

Rights of Consumers

Patients on admission to a mental health or community care facility in the ACT are provided with information concerning their rights. Section 50 of the Act requires a designated person to advise a person orally of their rights and to provide the person with written information about rights and entitlements under the Act including:

- The right to obtain legal advice
- The right to seek a second opinion

Information is to be provided about the functions, addresses and telephone numbers of key offices including the Tribunal, the Supreme Court, the Magistrates Court, the Community Advocate, the Chief Psychiatrist, the Care Coordinator, the Legal Aid Commission and the Ombudsman. The information, wherever possible, is to be provided in a language with which the person is familiar and in a mode of communication that the person is most likely to understand. The community advocate is to be advised if it appears that the person is unable to understand the information contained in an information statement.

The Queensland *Mental Health Act* 2000 has an interesting provision, namely the right of an involuntary patient to have an 'allied person'. Section 340 states that the function of an allied person is to help the patient to represent his or her views, wishes and interests relating to that person's assessment, detention and treatment under the Act. Where the patient does not have the capacity to choose but by an advanced health directive under the Queensland *Powers of Attorney Act* 1998 (s35), has directed that a stated person be his or her allied person, the stated person is to be the allied person. This right might be of interest to consumers and carers in the ACT where there is shared sentiment that the consumer should be able to have someone of their choice involved in care and treatment decisions.

Questions

30. *Are any further provisions required which allow other people to advocate as a right for people who are unable to do this because of mental illness and mental dysfunction?*

Rights of Carers and Family Members

There is little reference to the rights of carers and family members in the current Act. This is in contrast to other mental health statutes including those of Scotland, Britain, Queensland, Northern Territory and the Model Mental Health Legislation. Section 26 of the UK *Mental Health Act* 1983 and section 254 of the *Mental Health (Care and Treatment) Act* 2003 of Scotland contain detailed definitions of 'nearest relative' and provide a hierarchy of options.

Of all Australian mental health statutes, the Northern Territory Act has perhaps the most comprehensive set of provisions concerning the rights of carers. Firstly, the Act uses the term 'primary care giver' which is defined as:

Person who because of his or her relationship with a person, whether that is through kinship, familiarity, marriage or a de facto relationship, has a sense of responsibility for that person and provides care and support for that person, whether or not the person lives with that person.

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Section 88 (3) of the Northern Territory Act provides for the primary care giver or a person who is closely involved in the treatment or care of the person to be given information about the person's treatment without the consent of the person unless an authorised psychiatric practitioner believes on reasonable grounds, that it is not in the best interests of the patient. Section 88 (4) provides the primary care giver with the right to appeal to the Tribunal against a decision to not provide information. Section 89 makes similar provisions for the involvement of the primary care giver in discharge planning.

Questions

31. *Are provisions required to reflect the needs of carers and family members in allowing access to medical information?*
32. *How would such provisions be balanced against the rights of the consumer?*

7 Treatment

7.1 Defining Treatment

Consumers and carers in the ACT have suggested it is important for an Act which governs mental health treatment to contain a definition of 'treatment'.²⁸ Other Australian mental health statutes do provide a definition of the term 'treatment'. For example, the NT Act provides a definition.²⁹

The WA Government recently accepted the following definition:

*Treatment is any therapy, whether a medical, psychological or social, or other therapeutic intervention, whether alone or in combination, that is intended to alleviate or prevent deterioration of a mental illness.*³⁰

Consumers and carers in the ACT have stressed the need for a definition of 'treatment' which is holistic and encompasses medical, psychological and social therapeutic interventions.

Questions

33. *Should the Act define treatment?*
34. *If, so what definitions of treatment could be considered during the review?*

²⁸ Mental Health Community Coalition of the Act, *Response to the Scoping Paper for the Review of the ACT Mental Health (Treatment and Care) Act*, MHCC, Nov 2005

²⁹ s 4 NT Mental Health and Related Services Act 1999

³⁰ WA Government, *The Way Forward for Mental Health Legislation in Western Australia, Government's Response to the Report of the Review of the Mental Health Act 1996*, 2004, p. 31

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7.2 *Consent*

The giving of consent, the capacity to give informed consent, procedures for determining that consent has been given and the grounds for authorising treatment without consent are key provisions for mental health legislation to address. The current Act, defines informed consent in Part 7, the part of the Act dealing with ECT and psychiatric surgery. Generally speaking, in order for a person to be considered capable of giving informed consent, a person needs to be capable of understanding what informed consent is, capable of understanding the effects of giving consent and able to communicate his or her decision to consent or to refuse to consent. Further, informed consent is defined as consent freely and voluntarily given and without inducements having been offered.

Questions

35. *Are any changes required to the current Act's provisions to ensure consent is properly made?*

7.3 *Advanced Treatment Directives*

Consumers and carers in the ACT are of the view that obstacles to early assessment and treatment might possibly be overcome if the Act was to recognise advanced directives. The terms 'advanced directives' and Ulysses Agreements have been used to cover various ways in which consumers and carers can empower others to make treatment decisions for consumers when they become unwell. These agreements enable people to express their treatment preferences and wishes in the event that they become temporarily incapable of making informed decisions. Sections 275-276 of the *Mental Health (Care and Treatment) Act 2003* of Scotland gives legal recognition to advanced directives and details provision for their making, withdrawal and confirmation. The Report of the Review of Mental Health Legislation in South Australia recommended that advanced directives by consumers to cover the times when they are temporarily incapacitated should be given legal recognition.

Questions

36. *Should advanced treatment directives by consumers to cover times when they are temporarily incapacitated as a result of mental illness be recognised?*

37. *What criteria will be important to ensure that directives are adequately made and managed (eg withdrawn)?*

7.4 *Authorisation of Treatment*

Under relevant UN Principles, treatment shall only be administered to involuntary patients under mental health law where it is urgently necessary or where an independent review body has approved a plan of treatment proposed by an authorised medical practitioner. It is important that all efforts are made to involve the person in the development of this plan and to ascertain the person's wishes and preferences.

Questions

38. *Are any changes required to the Act's provisions for the authorisation of treatment?*

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7.5 *Treatment, Care and Discharge Planning*

Since the current Act was introduced, other Australian jurisdictions have introduced provisions requiring treatment and/or care plans and discharge plans. Section 19A of the Victorian *Mental Health Act 1986* requires the development of treatment plans and their regular review by the Board as does the Northern Territory.³¹

Questions

39. *Should the Act make provisions for treatment and/or care plans and for discharge plans? What type of provisions might be considered?*

7.6 *Chief Psychiatrist and Community Care Coordinator*

The current Act contains specific responsibilities for the Chief Psychiatrist (s108) and the Community Care Coordinator (s120). The Chief Psychiatrist has responsibilities for the treatment and care of mentally ill persons under the Act whilst the Community Care Coordinator has responsibility for the care of people with mental dysfunction under the Act. The current review invites comment on the roles of these two statutory positions.

7.7 *Regulation of Certain Treatments eg ECT, Psychosurgery, Restraint and Seclusion, Non-Psychiatric Treatment, Major Medical Procedures*

The current Act has provisions governing certain forms of treatments and interventions including ECT, psychiatric surgery, restraint and seclusion, non-psychiatric treatment, and major medical procedures. The review seeks comment on these provisions contained largely in Part 7 of the Act.

8 Disclosure of Information

Different views and interests need to be balanced when considering the issues of privacy and confidentiality. The same is true when private and confidential personal and health information is disclosed. People with mental illness have a right to personal autonomy and to control who may access what information about them. Inappropriate disclosure of information about a person's mental health or treatment has the potential to be highly stigmatising. People who are mentally ill generally have the same protection of confidentiality and privacy as other members of society. However the balance to be struck between competing views in relation to privacy and information disclosure is heightened in the context of mental health treatment and care. A major reason for this, is that mental illness and other mental disorders can result in periods where a person lacks capacity to make informed and reasonable decisions.

8.1 *The ACT - Current Situation*

The provisions of the ACT *Mental Health (Treatment & Care) Act 1994* and the ACT *Health Records (Privacy & Access) Act 1997* result in authorised mental health practitioners being able to disclose information about a person's care and treatment without the person's consent

³¹ *Northern Territory Mental Health and Related Services Act 1999* detailed requirement for treatment plans and discharge plans eg ss 34, 87-88 & 91

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only when they believe, on reasonable grounds, that use of certain information is necessary to prevent or lessen a significant risk to the life or physical, mental or emotional health of the consumer or another person. Any change to this legal situation must be compatible with the ACT *Human Rights Act* 2004.

Family members and other people close to a person with a mental illness who have a direct and ongoing supportive and caring role, hold the view that they at the very least need to have enough information to enable them to continue to safely provide support and care. Clinicians are concerned that the therapeutic relationship they have with their clients can be jeopardised by the disclosure of information. However, clinicians also recognise the importance of families and carers in a person's recovery. See 'Rights of Consumers and Carers', 6.3.4 page 20.

8.2 National Debate & Provisions in other States, Territories and Countries

Several Australian states including Western Australia, South Australia and NSW have considered the issues of privacy and information disclosure during recent reviews mental health legislation. Options for legislative change being considered by NSW include 'authorised disclosures':

- To guardians, family and primary carers if the information is reasonably required for the ongoing care of a client and the person who is receiving the information will be involved in providing the care;
- Where it is required in connection with the further treatment of the client; and
- Where other public authorities require the information for management purposes to prevent risk to a person or the public.³²

The Model Mental Health Legislation suggested the following clause for authorisation of information disclosure without the consent of the person:

Provision of information relevant to ongoing care and or treatment to a relative or other person who is considered to be closely involved in ongoing care and/or treatment of the person where disclosure is considered to be in he latter's best interests. (s150(c), p.103)

Section 91 (2)(e-f) of the Northern Territory *Mental Health and Related Services Act* 1999 provides for information disclosure to a person's representative or primary care giver or another person who is closely involved in the care and treatment of the person to whom the information relates where the disclosure is relevant to the ongoing care, treatment or rehabilitation of the person and the disclosure is considered to be in the best interests of the person. Section 1 (5) (b) of the *Mental Health (Care and Treatment) Act* 2003 of Scotland sets out an underpinning principle that an authorised person exercising functions under the Act shall have regard to the importance of providing such information to any carer of the patient as might assist the carer to care for the patient. These provisions provide examples of possible options that might be discussed during the current review.

Questions

40. *Should the Act allow for the disclosure of private and confidential health and mental health related information?*
41. *If so, when, to whom, for what purposes and what information should be disclosed?*

³² Ibid, pp.15-16

9 Children and Young People

The main questions for the review in relation to children and young people centre on how much detail the Act should contain for those under the age of 18. Currently, the Act contains few specific and expressed provisions for this group. The Report of the Review of the Western Australian *Mental Health Act 1996* (2004:52)³³ recognises that special provision should be made to protect children and adolescents receiving treatment and care for mental illness from a mental health service. The WA Government accepted the Report's recommendation that there should be a new part to the Act, entitled – Minors. Other Australian mental health statutes including NSW, Northern Territory and Queensland have expressed provisions for different age groups including those under the age of 14 and those aged 14-17.

9.1 Definitions

A question to be considered is whether any definitions for children and young people should be included in the Act. The WA government recently accepted that the following definitions be introduced into the Mental Health Act.

- A *competent minor* – a person aged 14-17 years, who in the view of an authorised medical officer acting in accordance with the Act, exhibits maturity in their behaviour sufficient to regard them as functioning at an adult level of decision making
- An adolescent should be defined as any other person aged 14-17 years
- A child should be defined as any person under the age of 14 years

Questions

42. Should the new Act contain definitions for the different groups of children and young people aged less than 18 years?

43. If so, what definitions should this review consider?

9.2 Voluntary Admission - Treatment and Care of Children and Young People

A key question to be considered is whether a person aged less than 18 years can consent to voluntary treatment and if so, how old does that person need to be. Sections 13-15 of the NSW Act make provisions for voluntary (or informal) admission and treatment of three groups – those aged under 16, those aged 14-15 and those less than 14 years. The latter group cannot be voluntarily admitted and treated if the parent or guardian objects. Section 25 of the Northern Territory Act enables a person aged over 14 to apply to be admitted as a voluntary patient. This section also enables the parent or a guardian of a person aged under 18 to apply on behalf of a person aged under 18. A medical practitioner must assess the person and be satisfied that informed consent has been given and that the person is likely to benefit from treatment. The WA government has accepted the need for the Mental Health Act to clarify that a competent minor, aged 14-17, may be able to seek voluntary admissions to a mental health service and may be able to consent to treatment.

³³ WA Government, *The Way Forward for Mental Health Legislation in Western Australia, Government's Response to the Report of the Review of the Mental Health Act 1996*, 2004, pp. 52-53

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Questions

44. *Should the new Act contain provisions for voluntary treatment of children and young people aged under 18 years?*
45. *If so, at what age should a minor be considered capable of giving informed consent to voluntary admission and/or treatment?*
46. *Up to what age should a parent or guardian be able to authorise psychiatric treatment and/or care?*

9.3 *Involuntary Admission - Treatment and Care of Children and Young People*

- Whether the Act should provide specific provisions addressing involuntary treatment for different age groups of children and young people is a key question. A further question to be discussed is whether procedures for involuntary admission and treatment should be the same for certain children and young people as they are for adults. Any changes to the current legislation with respect to children will need to be compatible with the *Human Rights Act*.

Questions

47. *Should the new Act contain specific provisions for involuntary treatment of children and young people aged under 18 years?*
48. *If so, for which age groups?*
49. *Should the review processes be the same for children and young people as they are for adults who are involuntarily admitted and/or treated?*
50. *Should any special protections be provided for children and young people in relation to involuntary admission, treatment and care?*

9.4 *Children and Young People and the Children & Young Persons Act 1999*

Key questions for the review to consider include what the relationship between the ACT *Children and Young Persons Act 1999* and legislative provisions for mental health treatment. Discussion is required about the preferred framework intervention for the management of mental illness in minors through mental health or child welfare legislation. Which legislation takes precedence for what issues in relation to juvenile offenders also requires discussion.

Questions

51. *Under which legislation are the interests of minors requiring involuntary admission and treatment best served?*
52. *What should be the relationship between the Child and Young Persons Act 1999 and provisions in mental health legislation concerning the admission and treatment of minors?*

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9.5 Rights and Interests of Children and Young People under the Act Issues and Questions

Currently there appear to be no expressed provisions for the protection and promotion of the rights of children and young people under the Act. Some questions and issues for the review to consider include the following.

- When should a minor be able to exercise autonomous decision making in relation to mental health assessment, treatment and care?
- When is a minor capable of giving informed consent, what rights should they have in relation to information disclosure and the involvement of parents and guardians?
- What expressed provisions should the Act make in relation to minors and prohibited and prescribed psychiatric treatments?
- Should minors receiving mental health treatment and care under the Act be provided with specialist advocacy?
- What consideration, if any, should the Act give to the benefits of doing all that is possible to maintain and not undermine the benefits of the parental relationship?³⁴

10 Assessment, Treatment and Care of Forensic Offenders

Modern mental health and crimes legislation seeks to streamline and mainstream provisions for people who are subject to the criminal justice system who are in need of mental health assessment and treatment.

The Commonwealth, State and Territory jurisdictions have developed draft *National Statement of Principles for Forensic Mental Health*³⁵ during the last three years. The first principle requires that people who come into contact with the criminal justice system have the same rights to availability, access and quality of mental health care as the general population. This principle is to apply equally and irrespective of the nature or extent of a person's involvement with the criminal justice system. The principle is to apply from the point of first contact where police are called to an incident involving a person exhibiting disturbed behaviour to the point where the dealings of the criminal justice system are completed with that particular legal matter. There has been considerable public discussion about the need to improve responses to people who find themselves unwell and in conflict with the law. This section discusses some of the key forensic mental health issues and raises questions needing to be considered during the review.

³⁴ S 278 *Mental Health (Care and Treatment) Act 2003* Scotland

³⁵ Mental Health Branch Commonwealth Department of Health and Aged Care, *National Statement of Principles for Forensic Mental Health, Draft for Consultation*, Canberra 2002 Reference

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10.1 Defining Forensic Consumers

A person falls within the broad definition of forensic offenders if they have both a mental health problem and are in contact with the criminal justice system because of offending behaviour. They are a group of people who require therapeutic assessment and assistance and who require both management of risk posed to the community, and judicial determination of any alleged offence. The Commonwealth's Proposed National Statement of Principles for Forensic Mental Health list the target groups falling within the purview of forensic mental health. The groups listed are:

- Offenders or alleged offenders referred by police, courts, legal practitioners or independent statutory bodies for psychiatric assessment and/or treatment
- Alleged offenders detained, or on conditional release, as being unfit to plead or not guilty by reason of mental impairment
- Offenders or alleged offenders with mental illness ordered by courts or independent statutory bodies to be detained as an inpatient in a secure forensic facility
- Prisoners with mental illness requiring secure inpatient hospital treatment
- Selected high-risk offenders with a mental illness referred by releasing authorities
- Prisoners with mental illness requiring specialist mental health assessment and/or treatment in prison
- People with mental illness in mainstream mental health services who are a significant dangers to their carers or the community and who require the involvement of a specialist forensic mental health service

Those who suffer intellectual disability or substance abuse without co-morbid mental illness are not included.

Questions

53. What type of service should the ACT have to manage people with mental health conditions who engage in criminal behaviour?

10.2 The Government's Commitment to Forensic Consumers

Managing forensic mental health offenders and alleged offenders includes managing the risk the person poses to the community, managing the offending behaviour, and treating or stabilising the person's medical condition. The Government is working to ensure that all individuals requiring attention are contemplated by each stage of the new system. A number of changes are already underway. The first is the application of different definitions to criminal justice matters and mental health treatment matters. A definition of mental impairment in the Criminal Code 2002 to be applied to criminal law matters has been introduced and is now operating. This review will discuss the definitions for therapeutic matters, which will remain in the Mental Health (Treatment and Care) Act 1994.

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The Government has also committed to the following further changes.

- The development of systematic assessment processes for forensic mental health offenders and alleged offenders throughout the ACT's criminal justice system.
- The development of facilities appropriate to particular treatment, care or support for the needs of forensic mental health offenders and alleged offenders throughout the ACT's criminal justice system. This includes the provision of a secure mental health facility in conjunction with the development of the new acute psychiatric unit at Canberra Hospital.
- Increasing the availability of step down options through increased support packages and flexible accommodation options for forensic mental offenders and alleged offenders.
- Developing forensic mental health training for mental health workers in the non-government sector.

By implementing these and other changes, the Government is seeking to provide comprehensive health care to assist forensic offenders to stabilise, recover and to the greatest extent possible resume their role and life in the community whilst also ensuring the safety of the person and the community.

10.3 Systematic Issues and Dilemmas

When a person who is subject to the criminal justice system is also exhibiting behaviour indicative of mental ill health, a response is required from several different service systems, namely, health, police, courts and corrections. All of these systems have different imperatives and operate from different legal bases. The health and mental health systems have a therapeutic and health interests imperative and operate primarily under the Mental Health (Treatment and Care) Act, which is principally about therapeutic treatment or benefit. The criminal justice system operating under criminal law is concerned with legal questions of culpability and intent. The tension between criminal justice and health is discussed below in relation to definitions of mental health conditions and the different purposes of the health and criminal justice legislation.

10.3.1 Culpability and Definitional Issues

Australian criminal law presumes a person accused of a crime is mentally fit to plead to a charge and was mentally well at the time of an alleged offence. The issues of fitness to plead and culpability in relation to mental wellness are legal questions in criminal cases and should be tested as a legal question before a court. Clinical evidence needs to inform the court's deliberations, not determine the deliberations. The Mental Health (Treatment and Care) Act provides the basis for involuntary treatment for people who are so mentally unwell that they cannot determine treatment for themselves. The Act has clinically derived definitions of mental illness and mental dysfunction that inform which authority, the Chief Psychiatrist or the Care Coordinator, should administer orders made by the Mental Health Tribunal.

The Criminal Code has recently been amended and a new definition has been introduced, a definition of 'mental impairment'. This definition contemplates that any health condition that may affect mental capacity and enables the Court to test a defence of mental impairment. In contrast, the definitions of 'mental illness' and 'mental dysfunction' in the Mental Health (Treatment and Care) Act come into play at several points including when the Mental Health Tribunal hears matters concerning people who have been found unfit to plead and people who have been found not guilty on the ground of mental impairment and matters concerning

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psychiatric orders or community care orders. There is sometimes a blurring between the lines of criminal law and the Criminal Code and the lines of mental health treatment and mental health legislation. In other words, there is currently concern that there is a lack of clear distinctions between the legal process of the criminal law and the civil law governing the involuntary treatment of mentally unwell people.

Questions

54. *Should the Act provide orders for forensic mental health assessments and management plans?*
55. *Should the Act set out the dispositions available to courts for criminal matters involving forensic mental health offenders and alleged offenders?*
56. *What should be the role of the courts in relation to the release of people found not guilty on the grounds of mental illness or unfit to stand trial?*

10.3.2 Tension between Therapeutic and Forensic Purposes

Issues can arise from the fact that a range of powers under the Mental Health Act have both therapeutic and forensic purposes whilst the Act fails to distinguish between these two purposes and to make clear provisions for each. For example, restriction orders and emergency detention orders do not distinguish between situations involving an alleged crime and situations where a person is just very unwell. The result is a lack of clear assessment, treatment or therapeutic pathways for alleged offenders. There can also be other impacts of a procedural nature which arise from the Mental Health Tribunal and Courts having different operational and procedural rules. The methods used by the Tribunal to hear cases is inconsistent with the requirements of a criminal trial and could give rise to jeopardy.

Questions

57. *Should the Act distinguish between the management of people detained for therapeutic reasons and those detained for forensic reasons?*
58. *Is the Mental Health (Treatment and Care) Act 1994 the appropriate Act to contemplate the powers and procedures for managing forensic offenders?*
59. *Should the forensic matters be in a stand alone Act or incorporated into existing legislation dealing with criminal law?*

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10.4 Developing a Forensic Response in the ACT

Currently the ACT lacks a system for forensic management of forensic offenders. This leads to people either being directed to a therapeutic response or to a criminal justice response. Mental Health ACT noted in the National Mental Health Report 2002, that a lack of forensic resources placed additional pressure on existing inpatient services and the general health system. During the Review discussion is required about how forensic offenders can be provided with a structured response through the criminal process which includes appropriate assessment, management plans and tailored programs and interventions.

Questions

- 60. Should the Act set out appropriate powers for the Courts and relevant ACT agencies to detain, case manage, treat and review forensic mental health offenders and alleged offenders?*
- 61. What powers should be enacted to enable police, ambulance officers, and mental health officers to apprehend and transport people in this group?*

10.5 Evidence in Criminal Cases

The Mental Health Tribunal, under the existing Mental Health (Treatment and Care) Act 1994, has a role in providing evidence for the Courts in relation to an offender's mental condition.

Because the Tribunal is operating under a therapeutic imperative and under the requirements of the Mental Health (Treatment and Care) Act the evidence gathered often centres around questions of diagnosis instead of the legal questions being addressed by the Court. This Review, seeks the community's views on possible changes that could be made to ensure that the Courts can obtain the necessary expert mental health evidence and information.

Options discussed within government include:

- The possibility of enhancing the access of the Court to expert witnesses or advisers from Mental Health ACT for example, to assist the Court to assess evidence and information provided
- Clarification of the legal questions and evidentiary standards the mental health reports are to address
- The possibility of a requirement that where possible, mental health reports provide explanation and justification cross-referenced to clinically relevant research

Questions

- 62. Is the role of the Mental Health Tribunal in criminal matters appropriate and what improvements are required?*
- 63. Should additional steps be taken to improve the standard of the evidence gathered by the Mental Health Tribunal?*
- 64. Should the Courts have increased access to expert witnesses who give evidence to the Court in relation to mental health issues?*

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10.6 The Rights of Forensic Mental Health Consumers

As stated above, the UN Principles require that principles of human rights shall apply to lawfully imprisoned persons to the fullest extent possible, with only such modifications and exceptions as are necessary in the circumstances. This means that lawfully imprisoned persons requiring psychiatric treatment and care, should as far as possible, have the same rights of autonomy, review, appeal and complaint as other people with mental illness who are subject to mental health legislation.

Rights of Other Groups

In some Australian jurisdictions the question has been raised as to what consideration should be given to the rights of particular groups, including victims of crime, in relation to release decisions of people found unfit to stand trial or not guilty on the grounds of mental illness.

Should a court or a tribunal take into consideration the views of the victims of the crimes committed or any other groups with a legitimate interest when reviewing a forensic offender's possible need for continuing detention?

Questions

65. *Are any changes required to the current Act to protect the right of forensic patients and other lawfully imprisoned persons with mental illness?*
66. *Should a court or tribunal reviewing a forensic patient's detention, take into account views of other particular groups?*

10.7 Legislative Provisions Needed as a Result of the Building of the Alexander Maconochie Centre (ACT Prison)

The review of the ACT *Mental Health (Treatment and Care) Act* needs to consider the range of legislative provisions now required because of the imminent building and operation of the Alexander Maconochie Centre (The ACT Prison). Provisions in mental health legislation will be needed to ensure that mental health assessment, treatment and care is readily accessible to those detained in this new correctional centre. The provisions will need to be consistent with the philosophy and emphasis of the new centre, namely to ensure an integrated and seamless approach to the delivery of services for offenders as they move between prison, community corrections and the community and to provide continuity of knowledge of the offender, programs and other services.

Questions

67. *What mental health legislative provisions are required to ensure that people detained in the new ACT prison receive ready access to mental health assessment, treatment and care?*

11 Oversight and Protection of Rights

11.1 Oversight Bodies

There are a number of major oversight bodies involved with the protection and promotion of the rights of people subject to the provisions of the *Mental Health (Treatment and Care) Act*. These are:

- The Public (Community) Advocate
- Mental Health Official Visitors
- The Human Rights Commissioner
- The Health Services Commissioner

The roles and powers of each of these bodies are discussed in turn.

The Public (Community) Advocate is governed by the *Public Advocate Act 2005* as well as the statutory obligations mandated in the Act. The Public Advocate advocates for the rights of people with disabilities, represents people at enquiries, monitors services provided, investigates, reports and makes recommendations to the Minister, and exercises the functions given under the Mental Health Act. The Public Advocate may refer systematic matters to the Human Rights Commissioner. The Public Advocate has the right to view the medical records of any individual when undertaking an investigation.

The Mental Health Official Visitor visits and inspects mental health facilities inquiring into the adequacy, appropriateness and standard of services, the extent to which people are receiving the best possible treatment and care in the least restrictive manner, any contravention of the Act, and any other matter the Official Visitor considers appropriate having regard to the objectives of the Act. The Official Visitor has the right to view the medical records of any individual when undertaking an investigation.

The Human Rights Commission may attend any inquiry held by the Mental Health Tribunal, subject to the leave of the court, may identify, inquire into and review issues relating to matters that may be complained about under the Act (*Human Rights Commission Act 2004*). The Health Services and Human Rights Commissioners have the right to view the medical records of any individual when undertaking an investigation under the legislation.

Questions

68. What changes, if any, to the Act's provisions for oversight bodies are required or could be usefully considered?

12 Conclusion

This discussion paper outlines key points to be discussed and finalised within the Review process. The Review will not exclude issues that have not been included in the discussion paper but which arise as significant during the consultation process. There will be three public consultation processes to scrutinise any proposed amendments to the Act subsequent to the consultations on the discussion paper. Representatives of consumers, carers and other key stakeholders will advise government through the Review Advisory Committee on the proposed amendments addressing the issues arising out of the consultation process.

Appendix 1



Discussion Paper Feedback Form

Review of the Mental Health (Treatment and Care) Act 1994

Please complete the following questions regarding your views of the Discussion Paper for the Review of the Mental Health (Treatment and Care) Act 1994. Please return your completed feedback form to: Mental Health Act Review, Mental Health Policy Unit, Level 3, 1 Moore Street, GPO Box 825, Canberra City, ACT 2601 or by email to Russell.Killick@act.gov.au

1 *Keeping in mind that the Discussion Paper is designed to outline the issues, and not address the specific text of legislation at this time, did you feel the issues were clear and objective?*

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2 *Do you believe the issues expressed were relevant? Are there issues that should be removed or should have been included?*

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3 *Do you believe the Consultation Plan provides adequate opportunity for you to provide feedback throughout the review process?*

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Appendix 2

Scoping Paper

1 Definitions

- a. Mental Illness /disorder
- b. Mental Dysfunction
- c. Mental Impairment – & relation to Crimes Act

2 Civil / Forensic mental health Interaction

- d. Civil / forensic issues interwoven in MH Act
- e. Civil / forensic issues dealt with in separate parts of same MH Act, or
- f. Separate Civil MH and Forensic MH Acts

3 Human Rights Act

- a. the right to equality and non- discrimination,
- b. the right to freedom from inhuman and degrading treatment,
- c. the rights of family and children to protection,
- d. the right to life is also quite important given the issue of suicide and the protection of the public, and
- e. the right to a fair trial Proportionality
- f. Least restrictive practise
- g. Privacy
- h. Liberty and Security
- i. Free consent to medical treatment
- j. Freedom of Movement
- k. Rights and Responsibilities:
 - Consumers,
 - Carers,
 - Services,
 - Community,
- l. Preventative detention

4 Consumers

- a. Voluntary
- b. Non-protesting / capacity.
- c. In-voluntary.
 - Crisis
 - Custodial
 - Community

- d. Age:
 - Child, (Therapeutic Protection Orders S232 C&YP Act)
 - Youth,
 - Adult, and
 - Older Persons
- e. Advanced Agreements – (Medical Treatment Act)
- f. Privacy and release of information.

5 Carers

- g. Carer Advocacy
- h. Substitute decision maker – appointment, status
- i. Persons with parental responsibility (generally for under 16yos)
- j. Carers
 - Consultation
 - Notification of decisions
 - Treatment partners

6 Staff

- a. Service Standards: Public Sector, Private Sector & Community Services Sector
- b. Code of Practise
- c. Approved clinicians (Mental Health Officers)

7 Chief Psychiatrist

- a. Model on Chief Health Officer?

8 Care Coordinator & Community Care Orders

- a. In MH Act,
- b. In Disability Services Act 1991, or
- c. Stand-alone Act.

9 Treatment issues

- a. Early Intervention / crisis response
- b. Assessments
- c. Treatment orders
- d. Care Plans / Treatment Plan
 - Consumer / Carer participation &/or Sign off
- e. Involuntary ECT.
- f. Restraint & Seclusion

- 10 Transport issues
 - a. Powers for Ambulance officers
 - b. What powers should be in place to transport patients.
 - c. How should sedation for transport be authorised?

- 11 Oversight Structure; Roles & Functions
 - a. Public Advocate
 - b. Official Visitors
 - c. Human Rights & Discrimination Commissioner

- 12 Tribunal Issues
 - a. Obtaining reasons for Tribunal decisions by right.
 - b. Ways to increase quality and efficiency of Tribunal decisions
 - c. Fair trial issues under Human Rights Act

- 13 Cross Border
 - a. Recognition of other State mental health orders.
 - b. Articulation of Principle of involuntary persons having same rights to access appropriate services regardless of borders as do voluntary patients under the Australian Healthcare Agreement

- 14 Forensic Issues
 - a. Assessment for fitness to plead & culpability.
 - b. Powers to detain after charging.
 - c. Mental health dispositions
 - d. The voice of victims of crime.
 - e. Relationship to part 13 of the Crimes Act 1900
 - f. Forensic MH matters: Tribunal or court's responsibility?
 - g. Representation in forensic mh matters: DPP, Defence, health advocates, Public Advocate, etc
 - h. Role of Victim participation in hearings involving forensic mh offenders.
 - i. Management of forensic mh offenders in the community: the therapeutic / community safety balance.
 - j. What powers for restraint and managing violence should be put in place?
 - k. The role, functions and powers of the police, the forensic mental health team, and any other people involved in managing forensic offenders.

Appendix 3

Sources of Information on Mental Health Legislation

To download a copy of the ACT Mental Health (Treatment & Care) Act 1999

<http://www.legislation.act.gov.au/a/1994-44/current/rtf/1994-44.rtf>

Adelaide University Mental Health Resource

<http://www.adelaide.edu.au/library/guide/med/menthealth/legal.html>

Links on this page are divided into a number of sections: [South Australian legislation](#), [Interstate and Commonwealth legislation](#), [United Kingdom legislation](#), [Other legal documents](#). Lists of books and journal articles relating to mental health legislation can be found on [bibliographies and reading lists page](#).

Finding an Australian state's mental health legislation

<http://www.legislation.act.gov.au>

For other states replace 'act' with the name of the state eg NSW, SA, WA, NT, TAS, QLD

World Health Organisation

[WHO Resource Book on Mental Health, Human Rights, and Legislation](#)
Geneva, World Health Organization, 2005

<http://www.unhchr.ch/html/menu3/b/68.htm>

[Mental Health Care Law: Ten Basic Principles \(World Health Organization\) 1996](#)

This is an edited version of a WHO document which lists and describes ten basic principles of mental health care law. It also provides annotations for their implementation in practice.
http://www.who.int/mental_health/media/en/75.pdf

Mental Health Act Reviews

Tip – simply Google 'mental health act review'

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Publication No 06/0952 (300)

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CHINESE	如果你需要传译员的帮助，请打电话：
CROATIAN	Ako trebate pomoć tumača telefonirajte:
GREEK	Αν χρειάζεστε διερμηνέα τηλεφωνήστε στο
ITALIAN	Se avete bisogno di un interprete, telefonate al numero:
PERSIAN	اگر به ترجمه شفاهی احتیاج دارید به این شماره تلفن کنید:
PORTUGUESE	Se você precisar da ajuda de um intérprete, telefone:
SERBIAN	Ako vam je potrebna pomoć prevodnioca telefoniрајте:
SPANISH	Si necesita la asistencia de un intérprete, llame al:
TURKISH	Tercümana ihtiyacımız varsa lütfen telefon ediniz:
VIETNAMESE	Nếu bạn cần một người thông-ngôn hãy gọi điện-thoại:

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