ACT Government
Health

REF: FOI:17-54

[redacted]

Dear [redacted]

Thank you for your application under the ACT *Freedom of Information Act 1989* (the Act) received by ACT Health on 21 August 2017 requesting access to documents regarding reform to the *Mental Health (Treatment and Care) Act 1994*, the scope of the request was refined to meeting minutes and meeting papers including correspondence from the Review Advisory Committee meetings held between January 2006 and December 2014 that relate to voluntary care, voluntary treatment, voluntary patients, involuntary care, involuntary treatment or involuntary patients.

As Executive Director, Policy and Stakeholder Relations, I am an officer authorised to make a decision in respect of a request for information, under Section 22 of the Act. I have decided to waive the fees associated with this request.

After conducting a search of all relevant records, ACT Health has identified 341 pages of documents in its possession that meet the scope of your request. I have decided that selected documents are to be partially released in accordance with provisions under the Act, as outlined in the Schedule of Documents. The remainder of the document are released in full.

My decision is appealable under the Act. This means that if you are dissatisfied with this outcome you have a right to seek a review under Section 59 of the Act. If you wish to seek a review you should write to:

The Principal Officer
c/- FOI Coordinator
Executive Coordination
Health Directorate
GPO Box 825
CANBERRA ACT 2601

You have 28 days from the date of this letter to seek a review of the outcome or such other period as the Principal Officer permits.

Under Section 54 of the Act, if you are concerned about the processing of your request or related administrative matters, you may complain to the Ombudsman, who may conduct an independent investigation into your complaint. There is no fee for this, and the contact details are as follows:

The Ombudsman
GPO Box 442
CANBERRA ACT 2601

If you have any queries concerning this Directorate's processing of your request, or would like further information, please contact the Freedom of Information Coordinator on 6205 1340 or via email at: HealthFOI@act.gov.au

The *Mental Health Act 2015*, as with all legislation, is available to be amended. ACT Health is currently undertaking a review of the operations of the Mental Health Act 2015. I would like to invite you to share the findings of your research with the Mental Health Policy Unit and have your feedback included in the current review. If you would like more information on the review and how you can provide your feedback please feel free to contact Mr Jon Ord, manager of the Mental Health Policy Unit, ACT Health on 6205 7928 or via email at: jon.ord@act.gov.au

Yours sincerely

Matthew Richter
Executive Director
Policy and Stakeholder Relations

21 February 2018

ACT Government
Health

SCHEDULE OF DOCUMENTS

[redacted] - FOI17-54

FOLIO	ITEM	STATUS	REASON FOR EXEMPTION	Internet publication – YES/NO – if no, why not
1 - 3	Membership – Organisation and roles	Full Release	Not applicable	Yes
4	Review Advisory Committee Meeting Agenda – 21 August 2006	Full Release	Not applicable	Yes
5-10	Approach to the Consultations	Full Release	Not applicable	Yes
11-12	Review Advisory Committee Meeting Minutes – 21 August 2006	Full Release	Not applicable	Yes
13	Review Advisory Committee Meeting Agenda – 8 September 2006	Full Release	Not applicable	Yes
14-15	Reaction to Discussion papers - 8 September 2006	Full Release	Not applicable	Yes
16-17	Review Advisory Committee Meeting Minutes – 8 September 2006	Full Release	Not applicable	Yes
18	Review Advisory Committee Meeting Agenda –13 November 2006	Full Release	Not applicable	Yes
19-31	Report to RAC November 2006	Full Release	Not applicable	Yes
32-34	Review Advisory Committee Meeting Minutes – 13 November 2006	Full Release	Not applicable	Yes
35	Review Advisory Committee Meeting Agenda – 12 March 2007	Full Release	Not applicable	Yes
36-39	Review Advisory Committee Meeting Minutes – 12 March 2007	Full Release	Not applicable	Yes
40-46	Review Advisory Committee Meeting Minutes – 7 May 2007	Full Release	Not applicable	Yes
47	Review Advisory Committee Meeting Agenda – 25 June 2007	Full Release	Not applicable	Yes

48-50	Review Advisory Committee Meeting Minutes – 25 June 2007	Full Release	Not applicable	Yes
51	Review Advisory Committee Meeting Agenda – 16 April 2008	Full Release	Not applicable	Yes
52-79	Review Advisory Committee Meeting Minutes – 16 April 2008	Full Release	Not applicable	Yes
80	Review Advisory Committee Meeting Agenda – 10 December 2008	Full Release	Not applicable	Yes
81-86	Review Advisory Committee Meeting Minutes – 10 December 2008	Full Release	Not applicable	Yes
87	Review Advisory Committee Meeting Agenda – 24 March 2010	Full Release	Not applicable	Yes
88-108	Meeting papers - 24 March 2010	Full Release	Not applicable	Yes
109-128	Report on Case Study Workshop – 2 August 2010	Part Release Section 41	Identifiable Personal Information	Yes
129	Review Advisory Committee Meeting Agenda – 21 June 2010	Full Release	Not applicable	Yes
130-134	Review Advisory Committee Meeting Report – 21 June 2010	Full Release	Not applicable	Yes
135	Review Advisory Committee Meeting Agenda – 10 December 2010	Full Release	Not applicable	Yes
136-147	Review Advisory Committee Meeting Notes – 10 December 2010	Full Release	Not applicable	Yes
148-160	Review Advisory Committee Meeting Notes – 4 February 2011	Full Release	Not applicable	Yes
161	Review Advisory Committee Meeting Agenda – 20 June 2011	Full Release	Not applicable	Yes
162-163	Review Advisory Committee Meeting Notes – 20 June 2011	Full Release	Not applicable	Yes
164-165	Review Advisory Committee Meeting Agenda – 25 July 2011	Full Release	Not applicable	Yes

166	Review Advisory Committee Meeting Papers – 25 July 2011	Full Release	Not applicable	Yes
167-171	Review Advisory Committee Meeting Minutes – 25 July 2011	Full Release	Not applicable	Yes
172	Review Advisory Committee Meeting Agenda – 25 July 2011	Full Release	Not applicable	Yes
173	Review Advisory Committee Meeting Agenda – 2 September 2011	Full Release	Not applicable	Yes
174-179	Review Advisory Committee Meeting Notes – 2 September 2011	Full Release	Not applicable	Yes
180	Review Advisory Committee Meeting Agenda – 16 September 2011	Full Release	Not applicable	Yes
181	Review Advisory Committee Meeting Annotated Agenda – 16 September 2011	Full Release	Not applicable	Yes
182-184	Review Advisory Committee Meeting Notes – 16 September 2011	Full Release	Not applicable	Yes
185-16	Review Advisory Committee Meeting Annotated Agenda – 30 September 2011	Full Release	Not applicable	Yes
187-217	Review Advisory Committee Meeting Notes – 30 September 2011	Full Release	Not applicable	Yes
218	Review Advisory Committee Meeting Agenda – 30 September 2011	Full Release	Not applicable	Yes
219	Review Advisory Committee Meeting Annotated Agenda – 14 October 2011	Full Release	Not applicable	Yes
220-226	Review Advisory Committee Meeting Notes – 14 October2011	Part Release Section 41	Identifiable Personal Information	Yes
227	Review Advisory Committee Meeting Agenda – 21 October 2011	Full Release	Not applicable	Yes
228-232	Review Advisory Committee Meeting Notes – 21 October 2011	Full Release	Not applicable	Yes
233	Review Advisory Committee Meeting Agenda – 2 November 2012	Full Release	Not applicable	Yes

234-235	Review Advisory Committee Meeting Notes – 2 November 2012	Full Release	Not applicable	Yes
236-252	Review Advisory Committee Meeting Minutes – 2 November 2012	Full Release	Not applicable	Yes
253-256	Review Advisory Committee Meeting Minutes – 21 November 2012	Full Release	Not applicable	Yes
257-262	Review Advisory Committee Meeting Minutes – 28 November 2012	Full Release	Not applicable	Yes
263-269	Review Advisory Committee Meeting Minutes – 30 November 2012	Full Release	Not applicable	Yes
270	Review Advisory Committee Meeting Agenda – 5 December 2012	Full Release	Not applicable	Yes
271	Review Advisory Committee Meeting Agenda – 5 December 2012	Full Release	Not applicable	Yes
272	Review Advisory Committee Meeting Agenda - 28 November 2012	Full Release	Not applicable	Yes
273-288	Review Advisory Committee Meeting Minutes – 5 December 2012	Full Release	Not applicable	Yes
289-291	Review Advisory Committee Meeting Minutes – 3 June 2013	Full Release	Not applicable	Yes
292	Review Advisory Committee Meeting Agenda – 12 June 2013	Full Release	Not applicable	Yes
293-297	Review Advisory Committee Meeting Minutes – 12 June 2013	Full Release	Not applicable	Yes
298	Review Advisory Committee Meeting Agenda – 14 June 2013	Full Release	Not applicable	Yes
299-305	Review Advisory Committee Meeting Minutes – 12 June 2013	Full Release	Not applicable	Yes
306-341	Review Advisory Committee - Summary of Themes	Full Release	Not applicable	Yes

Review Advisory Committee (RAC) Membership – Organisations and Roles

MHA Review Team
Review Project Leader, Mental Health Policy Unit, Health Directorate
Review Policy Officer, Mental Health Policy Unit, Health Directorate
Director, Criminal Law Policy, JaCS
Senior Policy Officer, Criminal Law Policy, JaCS

Members

Community Organisation Representatives
Policy and Communications Manager, Carers ACT
Mental Health Carers Policy Officer, Carers ACT
Policy Officer, Mental Health Community Coalition
Executive Officer, Mental Health Community Coalition
Executive Officer, Advocacy for Inclusion ACT
Executive Officer, ACT Mental Health Consumer Network
Policy Officer, ACT Mental Health Consumer Network
Individual Representatives
Carer Representative
Consumer Representative
Director, Research School of Psychology, School of Health and Psychological Services, ANU
Directorate Representatives
Mental Health Consumer Consultant , Mental Health, Justice Health Alcohol and Drug Services
Mental Health Consumer Consultant , Mental Health, Justice Health Alcohol and Drug Services
Executive Director, Policy and Government Relations, Health Directorate

Manager, Mental Health Policy Unit, Health Directorate
Executive Director, Mental Health Justice Health Alcohol and Drug Service, Health Directorate
Director, Justice Health Services, Mental Health, Justice Health Alcohol and Drug Services
Chief Psychiatrist, Mental Health Justice Health Alcohol and Drug Services
Operational Director, Adult Mental Health Services
Community Care Coordinator (statutory role under the Mental Health Act)
Registrar, ACT Courts
Senior Manager, Business Policy, Corrections ACT
Senior Manager, Community Based Corrections, Corrections ACT
Executive Director, Corrections JACSD
Associate Director, Regulatory and Licensing Policy, JACSD
Senior Manager, Policy, Data and Research, Office of Children, Youth and Family Services (OCYFS), CSD
Director, Disability ACT, CSD
Manager, Individual Response Team, Disability ACT, CSD
Senior Policy Officer, Strategic Policy, CSD
Senior Manager, Social Policy and Implementation, CMTD
Manager, Social Policy and Implementation, CMTD
Agency Representatives
Community Policing, AFP
Community Policing, AFP
The President, ACT Civil and Administrative Tribunal
The Public Advocate
Principal Advocate, Public Advocate's Office
Principal Guardian, Public Advocate's Office
Senior Advocate, Public Advocate's Office
The Victims of Crime Commissioner

Policy Officer, Victims of Crime Commissioner's Office
The Human Rights and Discrimination Commissioner
The Health Services Commissioner
Principal Review Officer, Human Rights Commission
Human Rights and Discrimination Law Policy Advisor, Human Rights Commission
General Manager Operations, ACT Ambulance Service
Principal Official Visitor

Mental Health (Treatment and Care) Act 1994 Review

Review Advisory Committee

2pm – 4pm, Level 3 conference room, 11 Moore St Civic

Agenda

21 August 2006

1. Introduction

Introduction and welcome by the Chair

2. Previous Minutes

Nil

3. Business Arising

3.1 Introductions

- Introduction of the consultants
- Introductions around the RAC members - facilitated by the Consultants

3.2 Framework of the Review and release of the Discussion paper - Chair

3.3 RAC Terms of reference, roles and operations - facilitated by the consultants.

3.4 Risk assessment - facilitated by the consultants

3.5 The role and approach of the consultants- facilitated by the consultants

4. New Business

5. Next Meeting: TBA

Review of ACT Mental Health (treatment and care) Act 1994

Our approach to the consultations

Our approach

- Developmental and participatory – what can we learn from other processes, foster understandings, look for solutions
- Build partnership with PMG and RAC – bring independence to the consultations
- Pathfinder model – respect for existing networks, forums and organisations
- Respect for and understanding of consumer centred work – bridge building with others – use of language

- Different methods for different needs – mixed methods – focus groups, individual interviews, deliberative sessions, consumer sessions, carer sessions, single stakeholder groups, mixed stakeholder groups, combined consumer/carer/stakeholder groups
- Dedicated strategies for reaching Indigenous communities, families, consumers
- Dedicated strategies for reaching people from other cultural backgrounds

- Progressively testing issues/ideas/suggestions – use deliberative processes wherever we think that will achieve a solution or foster improved understandings
- Aware of risks, manage these well, avoid being risk averse

This Phase

- Between September and late October 2006
- 3 Focus groups - MHCN, Rainbow Room, MHS through Consumer Consultant - commenced discussions with MHCN
- 3 Focus groups with carers/natural supports – Carer's ACT, MIF, others?
- Series of focus groups – 4-6 - MHS, legislators, policy makers, NGO providers (commenced discussions with the Coalition) complaints/rights/advocacy/legal stakeholders

- Meet with Chair of the Ministerial Advisory Committee
- Plan to meet individually with Winnunga and Gugan Galwan and undertake Yarning sessions with Indigenous services/community
- Individual interviews?
- Receive and analyse written responses to Discussion Paper – encourage this
- Deliberative workshop with RAC on results in late October

DRAFT

ACT Health

Mental Health (Treatment and Care) Act 1994
Review

Review Advisory Committee (RAC)

Minutes
2pm, Conference Room, Level 3, 11 Moore St

21 August 2006

1. Present

Chair: Ian Thompson. Facilitators: Elizabeth Morgan, Helen Disney.
Present: Benny Hodges, Robyn James, Stephen Druitt, Russell Killick, Sean Moysey, Helen Watchirs, Jan Moerkerke, Jason Lee, Jennelle Reading, Mal Gibson, Mick Kilfoyle, Paula Howe, Peggy Brown, Roxane Shaw, Matt Hingston, Margaret Brodrick, Michael Chilcott, Eddie Issa, Richard Refshauge

2. Apologies

Brian McLeod, Barry Petrovski, Herb Krueger, James Ryan.

3. Introduction

Introduction and welcome by the chair. Recognition of the traditional custodians of the land – facilitators.

4. Previous minutes

Nil. First meeting.

5. Business

5.1. Introductions

- Introduction of the consultants
- Introductions around the RAC members - facilitated by the Consultants

5.2. Framework of the Review and release of the Discussion Paper – Chair

DRAFT

Privileged copies of the Discussion Paper were circulated and are not yet for public distribution. The release is expected to happen soon and RAC members will be notified when this occurs.

Some errors in the paper were noted at 2.1.2 and 2.1.1

5.3. RAC Terms of reference, roles and operations - facilitated by the consultants.

A consensus model will be adopted. One spokesperson will speak on behalf of the Committee. The Terms of Reference will be modified by the consultants.

5.4. Risk assessment exercise - facilitated by the consultants

5.5. The role and approach of the consultants- facilitated by the consultants

6. New business

No new business.

7. Next Meeting

8 September, 2pm – 4pm, Level 3 Conference Room, 11 Moore St Civic

Action summary 21 August 2006

Agenda Item No	TASK	Person	Completion Date

Mental Health (Treatment and Care) Act 1994 Review

Review Advisory Committee

2pm – 4pm, Level 3 conference room, 11 Moore St Civic

Agenda

8 September 2006

1. Introduction

Introduction and welcome by the Chair.

2. Apologies

Richard Refshauge, Brian McLeod, Peggy Brown, Ron Cahill, Mal Gibson, Mick Kilfoyle, Luke McAlary

3. Previous Minutes

4. **Business Arising**

4.1 Further Introductions

4.2 Revisiting the Terms of Reference

4.3 The release of the Discussion Paper and feedback process

4.4 The Consultation Plan

4.5 An update following the risk assessment exercise of last meeting

5. New Business

6. Next Meeting: TBA

ACT Mental Health Legislature Review

RAC Meeting 8 September 2006

Session on Initial reactions to the Discussion Paper on the Review

In this session we sought initial comments on the Discussion paper from members of the RAC. This is a raw list of the issues/questions to be explored with some grouping of issues:

- What do we know/can we learn from other jurisdictions on how to reconcile consumers/carers issues.
- Balance between consumer rights and consumer safety – the issue of best practice legislation
- Consumer, care and clinician relations - and the therapeutic relationship
- Dual diagnosis issues
- Rights to access services – for consumers and carers.
- How have advanced directives been dealt with so far in the ACT
- What has been learnt from research on Tribunals - particularly in relation to fairness and effectiveness? The process of the MH tribunal
- What is the policy framework which we want to drive the legislation
- How do we get to some statement/s of underlying principles around the legislation
- How aware are consumers of their rights – WHO Resource Book on Mental Health and Human Rights Legislation
- How does the legislation impact on or protect Indigenous people - how do we reach people in these communities.
- How legislation is implemented is really important –maintaining the consumer focus and the principles
- Resources must be available to back and support the legislation.
- The management of involuntary treatment and safeguards to protect rights. Trauma as a consequence of involuntary treatment
- Complexity of issues of 'public safety' and 'fitness to plead'
- Initiatives in other jurisdictions addressing issues around public safety.
- Links to legislation on victims' rights – difficult issues.
- How do we promote awareness of rights. And the need for a media strategy
- Who decides "competence" - assessment of capacity – consent/capacity and disclosure of information
- Sharing information – impacts of privacy legislation and the Health Records Act
- Discrimination – what are the experiences.
- Positive obligations – what would this look like.
- Broader context of the Act – links to support, access to services.
- Definitional issues – e.g. illness, dysfunction, diagnosis
- Culpability and definitions – implications for intervention.
- Children and young people – as carers too.

- Voluntary treatment/rights of access to treatment are desired

Mapping of other processes that groups are undertaking to prepare their input for the review

1. MHCN – has a consultant working on the legislation from the perspective of consumers.

2. HRO are doing a community consultation on the human rights legislation **(Helen Watchirs is this correct?)**

3. Not sure if there is a process being undertaken to work on the carer perspective

4. (ITAS (Disability Services) Young people with intellectual disabilities
    i. work happening on Disability Act – Andrew Whale/Lois Ford.
    ii. drawing on work in NZ.

5. MH Community Coalition – a process to engage with the sector.

6. Review of the Children and Young Peoples Act.

7. Review of the Tribunals – forum in 2 weeks

8. Attorney–General's Review of the Human rights ACT.

9. Cross border issues and ACT Government process.

DRAFT

ACT Health

Mental Health (Treatment and Care) Act 1994
Review

Review Advisory Committee (RAC)

Minutes
2pm, Conference Room, Level 3, 11 Moore St

8 September 2006

1. Present

Chair: Elizabeth Morgan, Helen Disney.
Present: Stephen Druitt, Barry Petrovski, David Lovegrove, Pru Borman, Deborah Merritt, Herb Krueger, Helen Watchirs, Jan Moerkerke, Jason Lee, Kate Scandrett, Maurice Walker, Meredith Hunter, Michael Chilcott, Paula Howe, Robyn Holder, Roxane Shaw, Sean Moysey, Anita Phillips, Alasdair Roy, Renate Moore, Russell Killick (minutes).

2. Apologies

Richard Refshauge, Brian McLeod, Peggy Brown, Ron Cahill, Mal Gibson, Mick Kilfoyle, Luke McAlary, Linda Trompf

3. Introduction

Introduction and welcome. Recognition of the traditional custodians of the land.

4. Previous minutes

21 August 2006 – accepted.

5. Business

5.1 Further Introductions

New members and those not present at the first meeting were introduced

5.2 Revisiting the Terms of Reference

The role of members of this committee was reviewed as well as the consensus model for decision making. The attached facilitator notes from the first meeting were distributed. There was no objection to the principles raised in this document.

5.3 The release of the Discussion Paper and feedback process

Members were reminded that feedback on the Discussion Paper is due by 30 October 2006 and can be forwarded to Russell Killick at Mental Health Policy. The issue of creating a Corrigendum to clarify information in the Paper was raised.

5.4 The Consultation Plan

Comment was invited on what issues should be considered in the consultation process. The following points were suggested for consideration:

- The rights of carers and the interaction between consumers, carers and clinicians. Advanced treatment directives.
- The process of the Mental Health Tribunal
- How legislation is implemented "on the ground"
- The importance of the policy driving the legislation.
- Balancing rights and safety
- The WHO Resource Book on Mental Health and Human Rights Legislation. How aware are consumers of their rights?
- How to provide adequate resources to back up changes in legislation.
- Decisions about 'Fitness' should be made more transparent
- Creating a statement of principle for the legislation
- The management of involuntary treatment and safeguards to protect rights. Trauma as a consequence of involuntary treatment
- Provisions for information sharing
- Definitional issues
- The experience of other jurisdictions
- Including relevant review such as ITAS (Disability Services), Review of the Children and Young People Act, Review of the Mental Health Tribunal, Attorney General's review of the Human Rights Act.
- The creation of a media strategy

For more detailed information see attached notes from the consultants.

6. New business

No new business.

7. Next Meeting

TBA – to be held in a room with more seating.

Mental Health (Treatment and Care) Act 1994 Review

Review Advisory Committee

2pm – 4:30pm, Level 1 Training Room, 1 Moore St Civic

Agenda

13 November 2006

1. Introduction

Introduction and welcome by the Chair.

2. Apologies

Sean Moysey, Jason Lee, Mick Kilfoyle, Dee McGrath, Roxane Shaw, Barry Petrovski, Andrew Whale,

3. Previous Minutes

8 September 2006

4. Business Arising

4.1 Further Introductions

4.2 The Discussion Paper and feedback

4.3 Consultant's report:

- Results of the consultations
- Key issues
- Where to from here

5. New Business

6. Next Meeting:

To be discussed

REPORT TO RAC NOVEMBER 2006

1. Introduction

The first phase of the consultation for the review of the ACT Mental Health legislation is now complete and has received a high level of support, generating considerable interest in the potential to shape a very contemporary Bill by 2008. Consultations have taken place with stakeholder, and consumer and carer groups between late September and November (see **Attachment 1**). The consultation process has involved:

- Interviews with key stakeholders
- Focus groups
- Roundtable discussions.

The consulting team has not yet met with staff from Calvary Hospital. A preliminary review of the literature, other review processes, the most relevant policy statements and framework reports, and analysis of current legislation in other jurisdictions, has also been completed. We are currently writing this up into a short literature and document review.

This phase has involved a much higher level of engagement and activity than originally planned but it has been an important step in engaging people with the review. We have been struck by the limited knowledge and understanding overall of the legislation. Many people have a detailed understanding of one or two key aspects of the legislation, only a very small number of people and organisations have a broad knowledge or understanding.

There is even less understanding and/or knowledge of some of the key ideas being explored in the potential new legislative framework. These ideas include the implications of the 2005 changes to the Health Records legislation, advanced directives, the role and functions of the Mental Health Tribunal, and forensic issues. The exceptions to this are the Mental Health Community Coalition (MHCC) and the ACT Mental Health Consumer Network (ACTMHCN). Both organisations have established working groups on the review and are undertaking extensive research for their submissions to the review in response to the Discussion Paper.

The Discussion Paper has been very widely distributed by the Policy Unit. The responses to the Paper have been minimal to date although several organisations and government agencies have been granted an extension of two weeks to respond; the deadline is November 10th. It is our assessment that there will need to be some education and information sessions on major issues over the next two to three months if consumers, carers and stakeholders are to be able to engage in discussions regarding well informed options for the new legislation.

Thus this report focuses on the main issues which have arisen from the consultations and from our preliminary research on international and national material. The NSW legislation is scheduled for a first reading in the sitting of NSW Parliament over the next two weeks. We are in contact with the drafting team for this legislative process.

This consultation phase has played an important educative role and raised awareness of the need to engage with the review. There is considerable interest in the ideas and issues being examined.

Thus this report contains:

- brief discussion of the principles which could underpin the legislation
- a summary report of the issues raised in the consultations
- a brief summary of the issues raised through the research and policy examination to date
- suggestions regarding how to progress some of the most challenging issues and questions.

2. Purpose of the Act

A wide range of principles has been identified as being the desired purpose behind the new mental health legislation. There is, overall, a high degree of consensus on the ideal principles; there is less agreement and optimism on how achievable these principles will be in practice. A common issue raised, in almost every consultation, was the essential link between the services and resources available for mental health and having a workable legislative framework.

There is widespread support for the ACT mental health legislation to protect, promote and improve the lives and overall mental health well being of citizens. Suggestions have been made that the name should be expanded to be the ***Mental Health (Prevention, Treatment and Care) Act.*** All groups consulted believe that legislation should help shape the nature of the services.

Other principles with widespread support across stakeholders and consumers and carers were that:

- the legislation should be rights based
- treatment and care should be provided in the least restrictive environment and with the least restrictive or intrusive methods, and
- voluntary access to treatment in a mental health facility should be readily available and enshrined as a right in the legislation.

There are a number of principles that were raised on which there are more diverse views. These include that the legislation should be promoting the rights of people with mental health issues, rather than protecting the public from "dangerous" patients; the guaranteeing of confidentiality regarding information concerning persons with a mental health issue. The other contentious principle relates to the rights of consumers to choose not to have treatment.

Attachment 2 contains a detailed summary of the full range of principles addressed and the level of support to date. This table identifies some of the key principles and indicates what level of support exists at this time across the full range of consumers, carers, and stakeholders consulted.

Where to from here

It is proposed that the wide range of principles be workshopped or redeveloped to incorporate existing and additional principles supported or proposed as underpinning the legislative framework.

3. Core issues

3.1 Advanced Directives/Agreements

There has been strong support for including advanced directives in the new legislation. Issues raised include that:

- there is not a common understanding of advanced directives,
- what is the legal status of advanced directives
- what is the status of the Trial currently being undertaken in the ACT,
- what has been learned from the Trial
- how does legislation deal with the right to withdraw agreements during acute episodes.

There is a very low level of knowledge and understanding about advanced agreements including amongst many mental health providers: both NGO and government. There is however very strong support for the concept and keen interest in understanding them better.

Where to from here

There needs to be an educative process around advanced directives/agreements. It is proposed to work closely with the ACTMHCN as they have been working on this issue for many years. The keynote address at the upcoming Network AGM is on advanced directives.

It is suggested that a small, time limited Review advisory Committee (RAC) Working Group be established to include consumers, carers, staff from Mental Health Services, including the Psychiatry Services Unit, the MHCC, and the Tribunal to develop a preferred position on what should be in the legislation and what issues would need to be addressed.

It is also suggested that:

- **the consultancy team drafts a two page Information sheet on advanced agreements for use over the next 4-6 months in exploring this inclusion in the legislation**
- **the RAC jointly hosts an information forum on Advanced Directives with the ACTMHCN early in 2007 to build a better knowledge base of the concept.**

3.2 Mental Health Tribunal

A range of issues has been raised about the Tribunal. The major issue is the location of the Tribunal in the Magistrates Court; there is a widely held view that the Tribunal should be located outside of the Courts. Amongst the suggested alternatives are within the Departments of Health or Justice and Community Safety (although there is less support for JACS as a location) in a new "super" Tribunal, or as a stand alone body. There is widespread support for a fundamental refiguring of the Tribunal.

Common and major issues regarding the Tribunal are:

- membership (including the position of President)
- the resourcing of the tribunal including payment of community members[1]

[1] The ACT is reportedly the only Australian Mental Health Tribunal which does not pay community members. As far as we have been able to establish this does seem to be the case.

- the operation and powers of the Tribunal
- the requirement that consumers must be given access to an advocate
- including a requirement for the Tribunal to consider advanced directives
- the sitting times and hours of operation, and
- appeal mechanisms.

Many of the alternatives for location of the Tribunal have significant resource implications.

Where to from here

During the consultations team members were informed about a review of ACT Tribunals that is currently being conducted. It is important that the consultants and RAC members work with that process to ensure that decisions complement each other. The Consultants and the ACT Health Mental Health Policy Unit will obtain a briefing on the ACT Tribunal Review process and directions.

It is proposed that a RAC Working Group be established to work on this aspect of the legislation and that this might be a long term working group. Membership should include consumer, carer, provider and Tribunal representatives.

3.3 Children and young people

Many stakeholders raised issues regarding the treatment of children in the legislation. This is also an issue in most contemporary current reviews, and has been in a number of recent reviews. Principles in the legislation should reflect best practice, including the right to have a say, the issues of competence and informed consent, who should have the authority to prescribe compulsory treatment and how to deal with children of parents with a mental illness.

The definition of 'competence' with respect to young people needs to be clarified. Several stakeholders have also raised issues related to the need to ensure the legislation applies similar principles to those in other legislation such as the child protection and family law legislation. Both of these areas address issues related to:

- the best interests of children
- consent and informed consent
- the role of guardians
- access to independent advocacy
- the right to have a say.

Matters were raised related to the children with mental health issues who also have parents with significant mental health issues and the complexities this can raise for GPs, psychiatrists, MHS staff, and community mental health providers.

Where to from here

It is our view that there is not enough information at present regarding the issues regarding children. The WHO 2005 Resource has some useful ideas and proposals which can be used to build this knowledge. We have also raised this with the Director of CAMHS who is keen to support a process to explore these issues and options.

It is proposed to establish a time limited Working Group, to include staff from CAMHS and the Division of GPs (DGPs), to fully explore issues related to children, and to recommend changes. We think this could be done in two

meetings, or at least assist us to have a clear sense of the directions within two meetings.

3.4 Forensic Issues

Forensic issues have emerged as one of the most contentious and complex topics. The level of knowledge again varies hugely across the stakeholder groups and also invokes the most significant concerns for consumers and carers. There was an almost unanimous view on what the problems are but no agreement on the solutions. The issues ranged from deleting any reference related to criminal matters in the legislation, through to establishing a clear preventative and supportive approach to forensic issues in the mental health legislation, and reviewing all of the criminal codes and other associated legislation to ensure that these apply the same principles to people with forensic and mental health issues as the mental health legislation.

Issues raised in the consultations included the differential treatment of people in the two systems, the role played by the Police, the rights of people with a mental illness or suspected mental illness to be treated by the mental health system.

This topic is extremely complex and has gained considerable attention in other legislative reviews. Other reviews have also required careful attention to intersecting legislation. The WHO Resource Book has a framework and proposals for addressing these issues.

We believe that this topic requires intensive work on issues such as the interface with criminal codes and other health and corrections legislation, whether the forensic provisions should be included in the Mental Health Act or dealt with in criminal codes and/or regulations.

Where to from here

It is proposed that there is a two stage process to address this topic given the complexities and contentiousness.

The first stage would be a facilitated workshop of key stakeholders in the forensics and mental health services system, using scenarios to tease out the criminal justice issues, the mental health issues, the joint issues, and what are the known intersecting legislative codes/regulations etc? It is also proposed that a mapping exercise be undertaken in order to ascertain what legislation, regulations and polices affect this area. This workshop would involve the MH Policy Unit staff, Dr Peggy Brown, Department of Justice and Community Safety, PSU, Belconnen Remand Centre Forensics Team, and the Tribunal.

From that workshop a Working Group would be recommended to investigate options and to explore other elements such as community safety, the Chief Psychiatrist's role, Community Care Coordinator functions, the Tribunal issues, the ACT Prison implications, cross border issues, involuntary treatment, etc. This work is likely to take many months and to be a longer term working group. This work would also inform the way in which any public consultation should occur as issues of community safety will be one of the most contentious and challenging aspects to address and to reconcile.

It is also proposed that the Consultants and MH Policy Unit staff meet with the team working on the mental health service planning to discuss any common issues emerging related to the forensic service system for people with mental health issues.

3.5 Voluntary and involuntary treatment

The consultations have revealed a high level of agreement that this is a major issue, but much less agreement on the solutions; with extreme views ranging from the abolition of some involuntary treatments, such as ECT, to strong support for advanced directives to specify and have some weight in decisions regarding treatment orders.

A major issue identified related to voluntary treatment is the difficulty faced by people seeking to admit themselves to acute care when they feel that they need support to prevent a future acute episode which leads to an involuntary order. Most consultations supported the notion that the legislation should enshrine this as a right. This has very important resource implications.

Other involuntary treatment issues include the role of the Chief Psychiatrist, the process for obtaining Psychiatric Treatment Orders, and the use of seclusion.

Where to from here

This is another issue on which most stakeholders need more information, including evidence regarding the efficacy of treatments, consumer experiences, advanced directives, advocacy and appeal processes etc. Some of the submissions to the review are also intending to address these issues in detail.

We are unclear how to progress this issue in relation to timing, namely whether to wait until the advanced directives and Tribunal work is progressed, or, whether a half day workshop would be useful for the RAC to understand the issues, hear the full range of options and ideas, what the WHO Resource proposes, how other jurisdictions are dealing with this, and then decide how to move forward. This needs discussion at Monday's meeting (13/11/06).

4. Other issues

Whilst there are a number of ideas which have been raised regarding changes to the legislation, many are subsets or linked to the broader issues raised above. We have attempted to present the macro level issues at this stage as there is obviously significant work to be done and we need to keep this manageable for all RAC members, and within our role and the scope of what we are contracted to do. The other issues which may require more substantial work over time, but are second order issues at this point, are summarised here.

4.1 Definitions

The definitions provoked much less attention than we envisaged and the Discussion Paper questions, whilst useful for raising the issues, were not easily answered by most stakeholders.

It has been suggested that the definition of mental dysfunction be removed from the Act. This raises major questions including will there be any unintended consequences of writing out mental dysfunction? It has been argued that many jurisdictions have removed mental dysfunction. However from our analysis this is not quite as clear as it may be thought. The NT, Victoria and Queensland have dealt with it and this information can be provided to the RAC. The Scottish Legislation includes mental dysfunction in the broad definition of 'mental disorder'.

Where to from here

We propose developing a brief Options Paper on the definitions for discussion by the RAC, drawing on the WHO Resource Book, other legislative approaches and the ideas proposed through submissions.

4.2 Privacy and confidentiality

Issues of importance raised in every consultation are:

- when it is appropriate to share information with carers, or other service providers
- how much this is a legislative issue, as opposed to policy and practice issue, was an issue.

The Corrigenda produced by the ACT Complaints and Health Commissioner has clarified that the Health Records Act has been amended in late 2005 to allow access to health information for other providers and families/carers in limited circumstances. However we were surprised at how few practitioners, including MH Services staff, were aware of this amendment.

Where to from here

This low level of awareness of the amendments suggests a need for a brief Issues Paper outlining these amendments and exploring whether these amendments adequately address issues related to privacy and confidentiality and what this means for the legislation.

4.3 Early intervention

It was agreed by all that early intervention is critical. This has significant resource implications that needs further discussion. We also need to examine how this is dealt with in the WHO Resource Book.

5. Follow up Research

We suggest that we prepare 2-page discussion papers on the four core issues to be worked through first in order to assist all stakeholders and consumers to understand the complexity of the issues: Advanced Treatment Directives; the Mental Health Tribunal; Children and Young People; Forensic Issues. These would form part of the Working Group tasks and could be used to help the Working Group discussions. Working Groups could then provide comments on the final versions which are used in future educative or information sharing strategies.

Some of the work required is likely to be beyond the capacity and expertise of the RAC and the scope of our contract. The meeting needs to discuss additional processes that may need to be established, for example, how MHS might address some key issues of concern to them, whether the DGPs or another body needs to do any specific work related to their roles etc.

We will also provide a proposed timetable on Monday for the Working Groups and the production of the Issues Papers.

ATTACHMENT 1: Consultations for review of the legislation

Date	Who	Where
25/9/06	Meeting – Dual Diagnosis (MH/D&A)	Tuggeranong Health Centre
27/9/06	Consumer Meeting	Rainbow Room
6/10/06	Meeting with PSU team leaders	PSU
9/10/06	Winnunga Staff Meeting	Winnunga
11/10/06	MHS Staff Focus group	Moore St Health Building
16/10/06	Gugan Gulwan	Gugan Gulwan
16/10/06	Consumer Carer Caucus	Griffin Centre
18/10/06	MHS Staff focus group	1 Moore St
18/10/06	Division of GPs	Weston
23/10/06	Multicultural Roundtable	Multicultural Centre
24/10/06	Justice Roundtable	1 Moore St
26/10/06	MHS Staff Focus Group	PSU
27/10/06	Forensic Case Tracking Group	Reserve Bank Building
30/10/06	Meeting with Ron Cahill (MHT)	Magistrate's Court
31/10/06	Carers Focus Group	Carers ACT
31/10/06	Carers Focus Group	Griffin Centre
1/11/06	Meeting with Peggy Brown	1 Moore St
1/11/06	Consumer Roundtable	Griffin Centre
1/11/06	Consumer Focus Group	Griffin Centre
2/11/06	NGOs Focus Group	1 Moore St
6/11/06	Young Carers	
7/11/06	PSU Focus Group	PSU
December	Division of Psychiatrists	Not yet confirmed
November	Calvary Hospital (Heyson Green)	Not yet confirmed

ATTACHMENT 2. PRINCIPLES TO UNDERPIN THE ACT MENTAL HEALTH LEGISLATION (Work in progress)

PRINCIPLE	SOURCE	SUPPORT FROM CONSULTATIONS
Fundamental aim of mental health legislation is to protect, promote and improve the lives and mental well being of citizens.	WHO p.1	VS (see last page for key)
Focus should be promoting the rights of people with mental health issues, rather than protecting the public from "dangerous" patients	WHO p.1	D
To be legally fair to people who have committed a crime because of a mental health issue and to prevent the abuse of people with a mental health issue who become part of the criminal justice system	WHO p 5	VS
Fundamental Freedoms and Basic Rights • Guarantee of access to best available mental health care • Treatment with humanity and respect for human dignity • Prohibition of discrimination • Right to exercise all civil, political, economic, social and cultural rights • Right to have a determination made by an independent statutory body • Right to a fair hearing, to legal representation, to review and to appeal	UN Principle 1	VS
Protection of the legal rights of minors, including where necessary, the appointment of a personal representative other than a family member.	UN Principle 2	VS
The right of a person with a mental health issue to live and work in the community, and if the person needs care that they have the right to be cared for in the cultural and geographic community in which they live.	UN Principles 3 & 7	VS (Right) D (how to achieve it)
The determination that a person has a mental illness must be made in accordance with internationally accepted standards and through medical examination conducted in accordance with procedures authorised by domestic law. This determination should not be made on the basis of political, economic or social status or membership of a cultural, racial or religious group. Also, family or professional conflict or non-conformity with prevailing values should not be determining factors.	UN Principles 4 & 5	VS
Confidentiality is guaranteed in respect of information concerning persons with a mental health issue.	UN Principle 6	D

PRINCIPLE	SOURCE	SUPPORT FROM CONSULTATIONS
People with a mental health issue have the right to receive appropriate health and social care at standards commensurate with those applicable to other ill persons, and to be protected from harm, including: • Unjustified medication; • Abuse by others; • Other acts causing mental distress or comfort	UN Principle 8	VS
Treatment and care should be provided in the least restrictive environment and with the least restrictive or intrusive method appropriate to need. Treatment plans must be provided in accordance with applicable standards of medical ethics and be directed towards enhancing personal autonomy.	UN Principle 9	VS
Medication must meet the best health needs of the person and be given for diagnostic or therapeutic reasons only, never as punishment or for the convenience of other. All medication must be properly prescribed by a medical practitioner and properly recorded in medical records	UN Principle 10	VS
Informed consent must be given except in the case of a prescribed plan of treatment given to an involuntary patient who lacks the capacity to consent. In this case an independent authority must be satisfied that the proposed plan is in the best interests of the patient. Exceptions can be made in situations of urgent necessity to prevent imminent harm. Physical restraint and time limited involuntary seclusion should be subject to approved procedures and used only to prevent imminent or immediate harm.	UN Principle 11	VS
Patients have rights to: • Recognition before the law; • Privacy; • Freedom of communication; • Freedom of religion; • Conditions of living as close as possible to everyday life. Patients must be informed of their rights in an appropriate form and language.	UN Principles 12 & 13	VS
Mental health facilities must have the same level of resources as other health establishments, especially in relation to staffing, equipment, care and treatment. The facilities must be inspected by competent authorities at regular intervals	UN Principle 14	D
A person who needs treatment in a mental health facility should have access to it on a voluntary	UN Principle	VS

PRINCIPLE	SOURCE	SUPPORT FROM CONSULTATIONS
basis, and that where possible admission should be on a voluntary basis.	15	
The criteria for involuntary admission are: • A qualified mental health practitioner should determine that the person has a mental illness and as a result there is a serious likelihood of harm to that person or others, or that failure to admit the person will lead to a serious deterioration in the condition which will preclude further treatment. • Involuntary treatment should be only for a short period pending review • Notice of this review should be given to the person, their family and their personal representative.	UN Principle 16	I
Individuals who are involuntarily detained must be reviewed at reasonable intervals by an independent body. The initial review should be as soon as possible after admission. The procedures should be simple, expeditious and there should be the right to appeal.	UN Principle 17	VS
Procedural safeguards should include the rights to: • an interpreter • legal representation • access to information • review • to present evidence at a hearing.	UN Principle 18	VS
The person must be given access to information from their own medical records subject to restrictions where there is a serious risk of harm to personal health or to the safety of others. The person has the right to have personal records amended.	UN Principle 19	VS
A person serving a criminal sentence or detained by the Police who is believed to have a mental illness receives the best available mental health care.	UN Principle 20	VS
Every patient and former patient has the right to make a complaint, and appropriate mechanisms are set up to promote compliance with the Principles, for inspection of mental health facilities, and for investigation and resolution of complaints.	UN Principle 21 & 22	VS
Early Intervention is critical.		VS (with recognition of resource implications)

RELATIONSHIP OF PRINCIPLES, POLICY AND LEGISLATION

PRINCIPLE	SOURCE	SUPPORT FROM CONSULTATIONS
Mental health law can reinforce goals and objectives of policy, such as: • Establishment of high quality mental health facilities and services • Access to high quality mental health services • Protection of human rights • Patients right to treatment • Development of robust procedural protections • Integration of people with mental health issues into the community • Promotion of mental health throughout the society by providing a legal framework for implementation and enforcement	WHO p 2	VS
Legislation can be used as a framework for policy development. It can: • establish a system of enforceable rights to protect people with mental health issues from discrimination and human rights violations; • set minimum qualifications for mental health professionals and support staff; • create affirmative action policies and programs to improve access to programs and support services	WHO p 2	VS

Key:

VS	Strongly supported
S	Supported
D	Different views
O	Opposed
N	Neutral
I	Insufficient information

References:

United Nations (1991) *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*

University of Newcastle, Centre for Health Law, Ethics and Policy (1994) *Report to the Australian Health Ministers' Advisory Council National Working Group on Mental Health Policy on Model Mental Health Legislation*

World Health Organisation (2005) *WHO Resource Book on Mental Health, Human Rights and Legislation* Geneva

DRAFT

ACT Health

Mental Health (Treatment and Care) Act 1994
Review

Review Advisory Committee (RAC)

Minutes
2pm, Training Room, Level 1, 1 Moore St

13 November 2006

1. Present

Chair: Ian Thompson.
Present: Elizabeth Morgan, Helen Disney, David Lovegrove, Stephen Price, Deborah Merritt, Herb Krueger, Jan Moerkerke, Maurice Walker, Meredith Hunter, Michael Chilcott, Robyn Holder, Sean Moysey, Alasdair Roy, Dawn Roberts, Don Byrne, Jenny Thompson, Linda Trompf, Luke McAlary, Peggy Brown, Mimi Dyall, Penelope Mathew, Matt Hingston, Russell Killick (minutes).

2. Apologies

Richard Refshauge, Jason Lee, Mick Kilfoyle, Dee McGrath, Roxane Shaw, Barry Petrovski, Andrew Whale, Renate Moore, Helen Watchirs, Anita Phillips, Jennelle Reading.

3. Introduction

Introduction and welcome.

4. Previous minutes

8 September 2006 – accepted.

5. Business

5.1 Further Introductions

Further introductions for new members. Brief overview of the review process for new members.

5.2 The Discussion Paper and Feedback

The deadline for feedback on the discussion paper ended on 30 October, however, extensions have been granted to some respondents. All further feedback is sought as soon as possible and by the end of the week if feasible. Feedback has been received and some particularly comprehensive feedback from the Mental Health

Consumer Network. Discuss on distributing this information to RAC members. A summary of feedback will be produced with some individual feedback presented in its entirety.

5.3 The Consultant's Report

The consultant's first written report was presented to the RAC (see attached). The report summarises the feedback from the consultations so far.

General feedback about the consultation was that there was good participation and willingness to discuss issues. There was variability in knowledge around the current legislation with many participants having little specific knowledge of the Mental Health Act or narrow knowledge of the parts that related to them. There was consensus on many problems with the current Act but less agreement and proposal on how to resolve these issues.

Key issues for the review were sought that were not captured in the consultant's report and drug and alcohol co-morbidity was suggested as well as the extent to which the Act should consider people with an intellectual disability.

5.4 Issues in Response to the Consultants Report

- Discussion arose around the differences between issues that are dealt with in policy and other legislation and those dealt with in Mental Health legislation. The Chair expressed that ACT Health did not want to exclude anything at this time and become too narrow, as there was potential to recommend changes to other Acts.

- The need to consider whether the aspirations put into law are achievable.

- The need for committee members to have access to reference material such as statistics on the use of the current Act, legislation in other jurisdictions, the New Zealand experience with Advanced Directives, recent changes to the Health Records Act, and WHO publications. Mental Health Policy Unit to compile some reference material for distribution to RAC members. The consultants will also supply some background information during the working groups and the Discussion Paper includes useful reference material. Any RAC member can obtain another copy of the Discussion Paper by contacting Russell Killick (62055177).

5.5 Timeframe for Actions

- The course of action set out in the "where to from here" sections of the consultants report was agreed.

- Discussion about the critical importance of agreeing on the purpose and principles of the ACT Mental Health Act. However, it was agreed that work on other key issues would continue in parallel. The next RAC meeting will be for half a day and will focus on the purpose and principles of the Act.

- Nominations were sought for participants in working groups for Forensic Issues, Advanced Agreements, the Mental Health Tribunal, and Children & Young People. The working group for Forensic Issues will commence in December and the others in early 2007. Details of the working groups will be sent shortly by email and all RAC members are invited to attend any or all of the working groups.

6. New business

No new business.

7. Next Meeting

11 December 2006, 8:30am – 12 noon, Level 1 Training Room, 1 Moore St

The subsequent meeting will be held in the last week of January or first week of February 2007.

Mental Health (Treatment and Care) Act 1994 Review

Review Advisory Committee

9:00am – 11:00am, Level 1 Training Room, 1 Moore St Civic

Agenda

12 March 2007

1. Introduction

Introduction and welcome by the Chair.

2. Apologies

Jennelle Reading (Care Coordinator / Community Health), Deborah Merritt (MH ACT), Mimi Dyall (ACT Corrections Services) Amanda Urbanc (MH ACT), Jenny Thompson.

3. Previous Minutes

13 November 2006

4. Business Arising

4.1 Further Introductions

4.2 The Discussion Paper and feedback

4.3 Consultant's report:

- Results of the consultations
- Key issues
- Where to from here

5. New Business

6. Next Meeting:

To be discussed

DRAFT

ACT Health

Mental Health (Treatment and Care) Act 1994
Review

Review Advisory Committee (RAC)

Minutes
9am - 11am, Training Room, Level 1, 1 Moore St

12 March 2007

1. Present

Chair: Linda Trompf

Elizabeth Morgan, Helen Disney, Robyn James, Jane Pepper, Sharon Steele, Richard Refshauge, Athol Morris, Ron Cahill, David Lovegrove, Stephen Price, Deborah Merritt, Herb Krueger, Michael Chilcott, Robyn Holder, Dawn Roberts, Don Byrne, Jenny Thompson, Luke McAlary, Peggy Brown, Mimi Dyall, Matt Hingston, Helen Watchirs, Sue Watson

2. Apologies

Barry Petrovski, Leanne Craze, Dee McGrath, Linda Crebbin, Kate Scandrett.

3. Introduction

Introduction and welcome.

4. Previous minutes

13 November 2006 – accepted.

5. Business

5.1 Discussion paper and feedback

The summary of feedback on the discussion paper for the review of the Mental Health Act from December 2006 was re-circulated. Sharon Steele to send out electronic versions of feedback to RAC members and hard copies can be provided upon request. Stephen Price is happy to send out the response from ACT Mental Health Consumer Network. It was noted that feedback from ACT Mental Health Consumer Network, Office of the Victims of

Crime Co-ordinator and the Mental Health Consumer Coalition ACT were lengthy and were not summarised.

RAC members are to read summary and provide any feedback or comment to Sharon Steele by 26 March 2007, for feedback to Elizabeth Morgan.

5.2 The Consultant's Report

The consultant's second written report was presented to the RAC. The report summarises consultations to date and outlines the progress made with the working groups.

The consultants noted that most RAC members are involved in working groups.

Forensics

All workshops/working groups have been well attended A smaller working group has been formed to progress issues. There needs to be research into WHO structure, Sean Moysey and Jane Pepper to work through this and to report to PMT, prior to presenting back to RAC in approximately 1 month.

RAC agreed that the proposed way forward is appropriate.

Advanced Directives

On 21 March 2007, the consultants', together with the Mental Health Consumer Network are convening a 4 hour forum titled *"I told you what I needed"*. The purpose of the forum is to inform participants about options and to explore legal instruments and other ways in which consumers living with mental health issues can have control over the direction of their lives.

It was suggested that The Canberra Times could be invited to the forum.

Ron Cahill reminded RAC that Advanced Directives may affect Guardianship law in relation to Powers of Attorney. This topic will be covered in the forum.

Children and Young People

The working group met 10 days ago and it is proposed that there will be two more sessions in March and April, to develop a preferred position for the PMT and the RAC. The group is looking at what needs to be in the Act in line with WHO principles. There were differing views raised around age of consent with some advocating 10, others 14.

Robyn Holder will hold separate discussions with Elizabeth Morgan and Helen Disney. Ron Cahill suggested that Peter Dingwall is the Childrens Court Magistrate and it may be appropriate to speak with him. Within the Children & Young People Act there are therapeutic options available, however within ACT there are no appropriate facilities, therefore therapeutic options are

unable to be utilised. Richard Refshauge to prepare a short report for Morgan and Disney.

It was suggested that ACT could mirror some of the practices of the Family Court and questions arose as to how Advanced Agreements or care plans could apply to children.

It was suggested that Linda Crebbin, Peter Dingwall and Athol Morris all be included in the Children & Young People working group. A representative of the ACT Mental Health Consumer Network would also like to be present just to listen to the issues.

Mental Health Tribunal

The Tribunals' report has not yet been released.

The Review team has been asked to wait for some direction regarding the Tribunals' review before proceeding with this working group.

5.3 General Research

The consultants have conducted research into the essential elements of the Trieste model, however were less successful with the Asturias model, given that they don't speak Spanish. It was suggested that the past Director of the Canberra Hospital or the Spanish Embassy may be able to assist.

Other research conducted is detailed in the consultants report (attached).

5.4 Options Paper and Consultation Meetings

The consultants questioned when they should be going public and how they should do public consultation. Should it be when the options paper is ready to go out or prior to drafting instructions?

The consultants will be providing an options paper late April or early May, however the consultations in the next stage will not be as extensive as the initial ones. It is proposed that there will be 4-5 forums across Canberra for mixed groups.

MHACT to prepare a bulletin for circulation to ensure that the community is aware of the review and keep them up to date with where it is up to.

It was suggested that leaflets could be left in doctors surgeries indicating the changes to the Act and an article be put in the Chronicle as it reaches the wider community.

Robyn Holder is to meet with the consultants regarding victims of serious offences and how to target them to have a say.

5.5 Summary of outcomes of Purposes & Principles

has conducted research on the Trieste model together with 12 other pieces of legislation. The provision for Mental Dysfunction is in very few. Most refer to Mental Disorder – or impaired intellectual function. Lois and Jenelle are looking at what the definition should look like. In other legislation there is increased emphasis on voluntary admissions and a focus on voluntary care. Ron Cahill suggested that the Commonwealth Crimes Act be looked at for the definition.

There was a discussion regarding the definition of consent. Richard Refshauge said that it would be useful to encapsulate the group that the legislation applies by identifying the people to whom it applies and working out if it applies to all or just certain groups. Steven Price warned that subtle points of law can have major ramifications.

The consultants decided that there is a need for another working group to progress the purpose and principles of the Act including definition and structure. Members of the working group are Peggy Brown (or her delegate), Helen Watchirs, Richard Refshauge, Stephen Price, Don Byrne, Sue Watson, Matt Hingston and Sharon Steele. The first working group meeting will be held at 9am on Monday 26 March 2007, place to be advised.

6. New business

No new business.

7. Next Meeting

Monday 7 May 2007, 9am – 12pm.

ACTION ITEMS

Agenda Item No	TASK	Person	Completion Date
5.1	Send out electronic versions of feedback to RAC members	Sharon Steele	1 week
5.1	RAC members to provide feedback or comment to Sharon	RAC members	26/3/07
5.2	Forensic working group - Research into WHO structure	Sean Moysey & Jane Pepper	To go to PMT prior to RAC
5.2 & 5.4	Consultants to meet with Robyn Holder to discuss separate issues	Morgan & Disney	7/5/07
5.2	Morgan & Disney to talk to Peter Dingwall about legislative issues	Morgan & Disney	7/5/07
5.2	Prepare short report re: problems within the C&YP Act	Richard Refshauge	Before next meeting
5.2	Linda Crebbin, Peter Dingwall, Athol Morris & consumer network to be included in C&YP working group	Morgan & Disney	Prior to next C&YP working group
5.4	MH policy unit to prepare a bulletin on the review for circulation	Mental Health Policy Unit	1 week

DRAFT

ACT Health

Mental Health (Treatment and Care) Act 1994
Review

Review Advisory Committee (RAC)

7 MAY 2007
Minutes
9am - 11am, Training Room, Level 1, 1 Moore St

1. Present

Chair: Linda Trompf

Elizabeth Morgan, Helen Disney, Robyn James, Richard Refshauge, Michael Chilcott, Athol Morris, Ron Cahill, Sean Moysey, Jason Lee, Dee McGrath, David Lovegrove, Stephen Price, Simon Viereck, Barry Petrovski, Herb Krueger, Kevin Kidd, Dawn Roberts, Luke McAlary, Matt Hingston, Helen Watchirs, Sue Watson, Anita Phillips, Brian Mcleod, Richard Bromhead.

2. Apologies

Deborah Merritt, Linda Crebbin, Kate Scandrett, Robyn Holder, Don Byrne, Jenny Thompson, Peggy Brown, Jennelle Reading, Amanda Urbanc, Mimi Dyall.

3. Introduction

Introduction and welcome.

4. Previous minutes

Minutes from 12 March 2006 – accepted with amendments (as attached).

5. Business

5.1 The Consultant's Report

Elizabeth Morgan requested that the *Directions for Options Paper* is not circulated beyond the RAC as it is a very crude summary of the possible directions and is for the purpose of discussing with the RAC.

DRAFT

Morgan Disney sought RAC responses on the broad ideas and issues outlined in the Directions paper prior to drafting the Options Paper. Morgan Disney are also seeking RAC responses on the structure of the Options Paper.

ACTION: RAC members to respond to *Directions Paper* by 18 May 2007 to Morgan Disney or the Mental Health Policy Unit.

Principles and Purpose

There are threshold issues to agree on before some other elements are agreed. The issue of the extent to which the Act should or can have a primary focus of voluntary treatment remains unresolved and needs some further discussion.

Forensics

Following the last meeting the small group has progressed the proposal for a separate Act and has looked at the areas identified in the WHO framework for forensic mental health laws. However this task has been harder than originally thought.

Advanced Directives

Clear agreement on the importance of including future care statements in some way.

Children and Young People

Proceeding well with good participation by all members. Strong agreement emerging about the directions.

Mental Health Tribunal

The ACT Review of Tribunals is not yet public but there is strong agreement that the Tribunal needs major change including locating it independent of the justice system, membership, use of future care statements, and functions.

The Review team had been asked to wait for some direction regarding the Tribunals' review before proceeding with this working group but given how long this is talking they will need to progress this within the next 4 weeks

5.2 Options Paper Discussion

Themes emerging clearly

- The Tribunal needs to change

- Voluntary Treatment – to inform the community. (hopefully the process of the Review will address issues of stigma.)
- Forensic issues – Stephen Price (ACTMHCN): separate Act in the ACT critical. Separate processes – NSW has two separate Acts one essentially covering civil and the other covering forensic mental health they are cross referenced and Qld, England & Wales, Scotland have one Act covering both issues.

Threshold issues

- Act to deal with involuntary Treatment (Qld Act)
- Strong Prevention, Voluntary Treatment focus (Scottish Act)
- "Consent", "capacity" and "competence" need to be defined and addressed (Ron Cahill)
- Role of Guardianship and the Mental Health Act
- Role of Police / Ambulance (need to invite AFP & ESA - Richard Refshauge)
- Individual Advocacy (Stephen Price - Tasmanian Act is one model)
- Best interest advocacy - as distinct from individual advocacy (Ron Cahill)

Alarm Bells

Ambulance response - significant shift for ambulance officers to have coercive powers (Herb Krueger)
Clarify what is the purpose of the transport (Sean Moysey)

ACTION MorganDisney to talk with ESA regarding their views.

Definitions

- mental illness/ mental disorder / mental dysfunction - should mental dysfunction be in this Act? (Matt Hingston)
- If the definitions are to narrow it may miss out people who need protection and care. Criminal Law only deals with behaviour. (Richard Refshauge)
- Antisocial personality disorder is covered in the England& Wales Act (Helen Watchirs)
- Symptoms and diagnosis discussions need to be flexible (Sean Moysey)
- Should there be a separate tribunal (eg Community Care Tribunal) for persons who don't have a mental illness but require protection and care? (Helen Disney)
- What are the advantages of what we currently have?
- We need to craft the Act comprehensively and focus the Act on mental illness alone (Stephen Price)
- If we have a narrow definition – what happens to those excluded?
- Morgan Disney need direction - a broad or a narrow definition is a threshold issue.
- What is finally decided will need to be integrated into other Health Acts.

- Need to be aware of the workability of an Act.
- Through the legislation need to document in writing to the person reasons why a person is denied service. The State needs to show that everything has been done prior to involuntary processes (Simon Viereck MHCN).
- This type of documentation is already part of the process (Herb Krueger)
- Some legislative provisions for 2nd opinions and documentation are in other Acts (Helen Watchirs)
- Issue of clarity of access – accountability already through existing principles. If service delivery is regulated then services may become more restricted so as to concentrate on delivering the legislated requirements. (Kevin Kidd)
- We are looking to cater for multiple and complex needs. South Australia and Victoria are seriously looking at the existing ACT community care orders model. (Ron Cahill)

Forensic System

This is new to the Territory and the ACT Prison has bought the need into focus.

Threshold issues

- Should the ACT Crimes Act Part 13 come out to a Forensic Mental Health Act?
- This would not make sense, however Part 13 of the Crimes Act could be incorporated in FMH provisions or Act as a footnote so as to be readily available for reference to stakeholders (Richard Refshauge)
- It is not clear why there needs to be another Act – there are human rights considerations for keeping forensic mental health provisions within the Mental Health Act. (Richard Refshauge)
- There are problems with the intersection of mental health acts and crimes acts (Simon Viereck and Stephen Price)
- Struggle in the Territory in the Court system assessments need to reflect "fitness to plea" and "culpability" rather than therapeutic that is the direction of the current mental health act. (Sean Moysey)

ACTION: Forensic Working Group to work on principles for a separate Act or a separate section of the Act

Tribunal Discussion

- Options for locating the Tribunals outside the Court system
- Shortage of psychiatrists in the ACT – what will happen when the ACT prisoners come home – demand on the system
- Will the Tribunal also have a "Gatekeeper" role (Richard Refshauge)
- Currently the Tribunals have both a gatekeeper and therapeutic role, this can be conflicting (Sean Moysey)
- Role of Advocates:

- social rights
- individual
- best interest (Brian Mcleod)

ACTION: Linda and/or Richard to find out where the Tribunal Review is up to and what the implications are for this review. Elizabeth will meet with Tribunal members and progress what we can.

5.3 Framework for Options Paper

What we have now
What has changed
What are the options – Pros
-- Cons
-- Preferred Options
Issues Papers for significant issues, case studies can be added to clarify issues

ACTION: Morgan Disney to structure Options Paper, the Paper will then go to the RAC and then back to PMT for final polish. (Options Paper will need to be cleared through ACT Health and JaCS Chief Executives and respective Ministers before release for public consultation)

6. New business

No new business.

7. Next Meeting

T.B.A.

DRAFT

ACTION ITEMS

Agenda Item No	TASK	Person	Completion Date
5.1	Response to *Directions Paper* to Morgan Disney or the Mental Health Policy Unit.	RAC members	18 May 2007
5.2	Talk with ESA regarding their views	Morgan Disney	1 week
5.2	Work on principles for one or two acts	Forensic Working Group	
5.2	Progress on Tribunal Review	Richard Bromhead	
5.3	Options Paper drafted, the Paper will then go to the RAC and then back to PMT for final polish.	Morgan Disney	

Review Advisory Committee
7th May 2007
Attendance

NAME	ORGANISATION	CONTACT PHONE AND/OR EMAIL
Barry Petrovski	MHCC ACT	
Richard Refshauge	DPP	
Michael Chilcott	DPP	
Herb Krueger	MHACT	
Dawn Roberts	ACTDGP	
Dee McGrath	Carers ACT	
Luke McAlary	Chief Ministers Dept	
Sue Watson	Disability ACT	
Matt Hingston	Public Advocate/Care Co-ord Office	
Brian McLeod	PH ACT	
Stephen Price	ACTMHCN	
Jason Lee	Legal Aid	
Sean Moysey	Criminal law Dept Justice and Comm. Safety	
Ron Cahill	President Mental Health Tribunal	
Athol Morris	Magistrates Court & Tribunal	
Helen Watchirs	Human Rights &Discrimination Commissioner	
Kevin Kidd	A/g Director of Mental Health	
Anita Phillips	ACT Public Advocate	
Helen Disney		
Elizabeth Morgan		
Robyn James		
Linda Trompf		
Richard Bromhead		
Simon (MHCN)		
David Lovegove		

Mental Health (Treatment and Care) Act 1994 Review

Review Advisory Committee

9:00am – 11:00am, Level 1 Training Room, 1 Moore St Civic

Agenda

25 June 2007

1. Introduction

Introduction and welcome by the Chair.

2. Apologies

3. Previous Minutes

7 May 2007

4. Business Arising

4.1. Process of developing the paper and threshold issues

4.2. Initial reactions and key emerging issues

4.3. Summarising and prioritising the emerging issues

4.4. Small group discussions on key issues (30 minutes)

4.5. Large group plenary

4.6. Summarising outcomes, agreements, differences

4.7. Process from here

5. New Business

6. Next Meeting:

To be advised

DRAFT

ACT Health

Mental Health (Treatment and Care) Act 1994
Review

Review Advisory Committee (RAC)

25 JUNE 2007
Minutes
9am - 12am, Training Room, Level 1, 1 Moore St

1. Present

Chair: Linda Trompf

Elizabeth Morgan, Helen Disney, Linda Trompf, Deborah Merritt, Peggy Brown, Jenny Thompson, Dawn Roberts, Helen Watchirs, Susan Helyar, Luke McAlary, Sue Watson, Jason Lee, Vickie Crisp, Barry Petrovski, David Lovegrove, Leanne Craze, Stephen Price, Simon Viereck, Michael Chilcott, Mimi Dyall, Meredith Hunter, Athol Morris, Herb Krueger, Steve Druitt, Robyn Holder, Brian Mcleod, Kate Scandrett, Don Byrne, Matt Hingston, Sean Moysey, Richard Bromhead
? Vivian ,

2. Apologies

Linda Crebbin, James Ryan, Jennelle Reading, Phillip Moss.

3. Introduction

Introduction and welcome.

4. Previous minutes

Minutes from 7 May 2006 – accepted.

5. Business

5.1 The Consultant's Report

Elizabeth Morgan requested initial reactions and threshold issues for Draft Options Paper as circulated.

The majority of RAC members present said that they had an overall positive impression of the Options Paper and that it was close to completion. A minority said that the options paper as presented was not nearly ready for consultation or was alarming.
Many members went on to say that while their overall impression was positive various issues needed further work.

5.2 Summarisation of Emerging Issues from Initial Reactions

These included:

1. Definition options around:
    a. mental illness, disorder, dysfunction
    b. Consent, Capacity and Competency
2. Tribunals
3. Children and Young People
4. Advocates model
5. Statuary oversight bodies
6. Forensic mental health options
7. Voluntary Assessment / treatment
8. Carer rights
9. Advanced Agreements

5.3 Small Group Discussion

RAC divided into small groups to discuss "definitions" for 20 minutes,

Then Reference Committee divided into interest groups to discuss Forensic MH 2 groups, Tribunal, Advanced Agreements, Carer / Consumer Rights, Voluntary assessment / treatment as a Right,

<u>Group feedback:</u>

- The options paper needs to identify the different populations the Act may cover.
- The paper needs to discuss more what are the consequences of the various options
- The paper should clarify when the State should intervene against a person's intentions.
- The paper needs to background the ACT unique legal context,
- the various options could discuss what happens in other jurisdictions.
- Need to state what is the justification for radical change from the status quo.

<u>Forensic</u>

- The pros and cons need better articulation and expansion
- The difference of purpose for forensic mental health from civil mental health needs better articulation
- this leads to options for separate section or legislation options.

<u>Tribunals</u>

More detail on location and the lawyers and tribunals section

DRAFT

Advanced Agreements –
- the issue is about "capacity" Tribunal is the body and accountable
- if the Tribunal override an AA then appeal process that is timely

Carer / Consumer
- identify significant other
- children of parents with MI
- withhold consent
- intersection with the Privacy Act

Voluntary "treatment" as a right
- Discuss whether it is treatment or assessment that is meant – treatment as "a right" if clinically indicated and available.
- Definition of "treatment"
- Policy level issues

6. New business

No new business.

7. Next Meeting

T.B.A.

ACTION ITEMS

Agenda Item No	TASK	Person	Completion Date
5	Options Paper redrafted, in light of RAC feedback	Morgan Disney	2 July 07
	Options Paper reviewed by PMT	PMT	5 July 07

Mental Health (Treatment and Care) Act 1994 Review

Review Advisory Committee

9:00am – 11:45am, Level 1, Training Room, 1 Moore Street, Civic

Agenda

16 April 2008

1. **Introduction and welcome**
2. **Apologies**
3. **New Business**

   3.1 RAC decision-making process

   3.2 Presentation. Consultant's Report on Stage 2 Consultation – Chapters 1 and 2

   3.3 Forward process (Chapter 4)

   3.4 Presentation. Consultant's Report on Stage 2 Consultation – Chapter 3 issues (resolutions on process per item)

4. **Next Meeting**

DRAFT

ACT Health

Mental Health (Treatment and Care) Act 1994
Review

Review Advisory Committee (RAC)

16 APRIL 2008
Minutes
9am - 12am, Training Room, Level 1, 1 Moore St

1. Introduction

Richard Bromhead: Acting Chair & ACT Health

2. Attendance

Sue Watson, Disability ACT; Robyn Holder, Victims of Crime Coordinator; Belinda Barnard, Matt Hingston, Human Rights Commission, Dawn Roberts, ACTDGP; Simon Vireck, David Lovegrove ACTMHCN; Dee McGrath, Carers ACT; Dr Peggy Brown, ACT Chief Psychiatrist; David Plant, Barry Petrovski, MHCC of ACT; Michael Chilcott, DPP; Christina Thompson, Trish Mackey, Sue Hockley Office of the Public Advocate; Nicole Mayo, JaCS; Ron Cahill, ACT MH Tribunal; Toni Hunt, ACT Corrective Services; Angela Greensill MHACT; Jenny Thompson RANZCP; Michael Edwards, Libby Trickett ACT Law Courts; Sid Chakrabarti Youth Coalition; Luke McAlary CMD; Martin Hockridge, ACT Legal Aid Office.

3. Apologies

Ross O'Donoughue ACT Health Chair RAC; Victor Martin JaCS; Andrew Whale Disability ACT; Janelle Reading ACT Care Coordinator; Sue Connor, Mental Health Principle Official Visitor, Herb Krueger ACMHN

4. New business

Maree: Copies of Aequitas Report and written submissions available for members of the RAC to take.

Richard: We don't have explicit permission for the submissions to be made public. We request that only the RAC representatives currently here have access to the papers.

Maree: Been a year since the last committee, new people. The review can be seen as restarting from this position. Wish of the secretariat, and Maree's intention, *to establish a way forward*. At a point where there has been an untidy development of various issues (some more ahead than others) and people who have been consulted (not everyone has been). Moving to the point where need to make recommendations, tidy up process of decision-making.

a) Have a look at decision-making process of RAC, in the next 15 minutes.
b) Give a presentation in relation to the report. Not going to summarise the whole report, will focus on process- direction needed for further work.
If we could, have discussion in the second part of the meeting.

Michael 1 (DPP): what is the forward timeframe for this process. My understanding is there should be a Bill in place now. What are we aiming for?

Maree: depends on what your views are at the end of the forum. The Minister of Health doesn't think we should rush the decision. No pressure, but do need a forward program.

Richard: Probably December 2010.

4.1 Decision making process

Slide: proposal for RAC decision-making.

Richard: (speaking to proposal): Essentially a response from people consulted, this is a working through implications if decision could not be reached. Resort to alternative to consensus only as a last resort. Proposed we looked at a balloting system if the RAC could not arrive at consensus. Experience of previous RAC meetings was there was fluidity in representatives and some organisations had more than one person here but if come to a balloting, how do we sort through that?

Maree:

- Basic proposal relies on deciding who is in the committee and who is not. People go back to agencies and to renominate their representative. Need to do this afresh.
- That all the representatives that appear at the RAC have authority to vote.
- Decision by consensus remains the primary way of decision-making.

RAC Discussion Summary: reflected the need to prioritise the RAC processes for consensus and that a show of hands helped the consensus process by indicating positions that could either be agreed or in need of further discussion, and that formal balloting was only a last resort if consensus not achieved. Dissenting views would be recorded not by number but 'significance' or strength of dissent.

Agencies requested to nominate a representative and a proxy, the representative or proxy if required would vote in the Ballot if one was required one vote per agency but participation in consensus building, show of hands etc could be with more people.

Ron: Important if we're going to vote to have decided who the agencies are

Maree: List available at door of agencies thought to be part of the committee. Don't want to take up meeting with this issue, needs to pass that role onto Agencies. Agencies by this proposal need to re-nominate for membership.

Maree: Inviting show of hands indicating level of consensus on motion

RESOLVED:

- **That agencies re-renominate their RAC membership, their representative and a proxy.**
- **That representatives should have the authority to commit their agency to views or recommendations.**
- **That 'decision-making by consensus' remain the primary mode.**
- **That where consensus is not possible, a ballot of the RAC would take place with the view to put forward "recommendations without consensus". The ballot would be limited to one member per agency.**
- **In the event that a ballot reveals a significant dissenting position that the terms of that position will be recorded.**

4.2 Presentation

The consultant's presentation summarised the issues addressed in detail in the Stage 2 Consultation Report with a focus on material contained in Chapter 2: The Model of Legislation and Chapter 4: Forward Process.

4.3 Discussion

RESOLVED:

That the focus of immediate forward action should be to facilitate RAC capability to make recommendations, with due diligence, in relation to a model of legislation at the earliest possible time.

4.3.1 Model of Legislation

RESOLVED:

The Committee authorises further investigation and report on:

- ***schemes for involuntary interventions in place in other jurisdictions;***
- ***rationale for detention of population groups not including mentally ill, in the ACT;***
- ***the identification of capacity and workability of a distinction between capacity and incapacity a structural element; and***
- ***best interests v risk of harm criteria for involuntary orders.***

ACTION OPTION SELECTED:

Consultant to investigate and report

4.3.2 Public Safety Concerns

RESOLVED:

That the Model of Legislation paper include investigation and summary of attitudes to public safety in the ACT, trends in risks to public safety, and the relationship between these risks and the mental health of offenders, including the number of offenders referred to the Mental Health Tribunal.

ACTION OPTION SELECTED:

JACS to manage (including, but not limited to, receipt of submissions)

4.3.3 Private sector regulation

RESOLVED:

That the Model of Legislation paper address the need for additional investigation into integration of private care arrangements for persons with mental illness or mental dysfunction within the ACT

4.3.4 Regulation of restrictive practices

RESOLVED:

That the Model of Legislation paper address possible mechanisms for regulating restrictive practices (seclusion, physical restraint, chemical restraint) in the care of people with mental illness and mental dysfunction

4.3.5 Outline of possible models

RESOLVED:

That the Model of Legislation paper includes a summary of the possible models of legislation arising from employing and preferring various combinations of the distinctions in legislative structure

4.3.6 Research into Act usage

RESOLVED:

That research be conducted to isolate basic demographic data related to

PTOs, CCOs and restriction orders granted over the most recent 12 month period (to be reported within the Model of Legislation paper).

ACTION OPTION SELECTED:

Courts and Tribunals to conduct

4.3.7 Forensics Paper

RESOLVED:

That the Committee request completion of the detailed report on options for forensic provisions (the Forensics paper in coordination with the preparation and delivery of the additional material in relation to the Models of legislation paper.

4.3.8 Statements of policy from Government

RESOLVED:

That the Committee request completion of the detailed report on options for forensic provisions (the Forensics paper in coordination with the preparation and delivery of the additional material in relation to the Models of legislation paper.

4.3.9 Consultation on new investigations

RESOLVED:

That the Committee authorises consultation within the Committee for the time being with further possibility of greater consultation in relation to the Models of Legislation paper and the Forensics Paper.

Substantial dissenting view: opportunity should be there for additional community input.

4.3.10 Completion of stage 2

RESOLVED:

That the Review specifically invite psychiatrists, GPs and individual tribunal members to make submissions in response to the issues represented in the Options Paper during the proposed new Stage 3 consultation period.

4.3.11 Report on 'new stage 3'

RESOLVED:

Authorising preparation of a report summarising consultation on:

- ***the Models of Legislation paper***
- ***the Forensics paper***
- ***completion of Options Paper consultation***

and a revised proposal for 'forward process'

5. Additional

Maree: in terms of next meeting, do you want to set up a monthly meeting or see the papers first?

Agreement to see papers first

Agreed, 2 months from today (mid- June 2008).

T.B.A.

Proceedings, 16th April Mental Health Building

1. Introduction

Richard: Acting as Chair because appointed executive director of policy unit in ACT Health, Ross, is unable to make it.

2. Apologies

Richard:

Victor
Andrew
Janelle
Sue Connor
Herb

Maree: Copies of Aequitas Report and Written submissions available for people to take

Richard: Don't have explicit permission for the submissions to be made public. Only the representatives currently here have access to the papers.

3. New business

Maree: Been a year since the last committee, new people. The review can be seen as restarting from this position. Wish of the secretariat, and Maree's intention, *to establish a way forward.* At a point where there has been an untidy development of various issues (some more ahead than others) and people who have been consulted (not everyone has been). Moving to the point where need to make recommendations, tidy up process of decision-making.

a) Have a look at decision-making process of RAC, in the next 15 minutes.

b) Give a presentation in relation to the report. Not going to summarise the whole report, will focus on process- direction needed for further work.

If we could, have discussion in the second part of the meeting.

Should be out of here by 15min to 12.

Michael 1 (DPP): what is the forward timeframe for this process. My understanding is there should be a Bill in place now. What are we aiming for?

Maree: depends on what your views are at the end of the forum. The Minister of Health doesn't think we should rush the decision. No pressure, but do need a forward program.

Richard: Probably December 2008.

3.1 Decision making process

Slide: proposal for RAC decision-making.

Richard: (speaking to proposal): Essentially a response from people consulted, this is a working through implications if decision could not be reached. Resort to alternative to consensus only as a last resort. Proposed we looked at a balloting system if the RAC could not arrive at consensus. Experience of previous RAC meetings was there was fluidity in representatives and some organisations had more than one person here but if come to a balloting, how do we sort through that?

Maree:

a) Basic proposal relies on deciding who is in the committee and who is not. People go back to agencies and to renominate their representative. Need to do this afresh.
b) That all the representatives that appear at the RAC have authority to vote
c) Decision by consensus remains the primary way of decision-making.
    a. Dee: Not a characteristic of our proceedings so far…
    b. Maree: The ballot has to take place if consensus is not apparent.
    c. Trish: concern is to not have to balance out the opinions.
    d. Maree: In the event of dissent we need to be able to identify and record it
    e. David L: if the process is more structured towards arriving at a consensus, probably more likely to reach that point. Perhaps be more systematic and structured, rather than having it all in the end.
    f. Maree: Do you think a show of hands is appropriate?
    g. David L: moving to a formal ballot process excludes any process to reach consensus. Show of hands part of process of reaching consensus. Decisions can be recorded- general and alternatives- without that having to be a formal counting.
    h. Maree: so using hands as an indicator of consensus rather than formal ballot
    i. David 1: yes
    j. Dee: problem with the show of hands- some organisations have more/fewer representatives.
    k. Maree: how to amend 'ballot'? 'A show of hands should be…'
    l. Sid: have to decide what 'not able to achieve a consensus' means.
    m. Maree: perhaps formal ballot a last resort.
    n. Trish: where would the other view be taken into account?
    o. Maree: opposing views recorded.
    p. 'Meeting process' procedure amended
    q. Maree: Dissenting view not by number but 'significance' or strength of dissent
    r. Robyn: What about when have no view?

s. Maree: having no view is fine, those with a view will be the ones creating decisions.
t. Peggy: When talking about consensus- agencies or RAC members in attendance.
u. Maree: Motion says one representative per agency.
v. Dee: understood from the email- wanted 'a' representative, didn't bring a proxy.
w. Maree: the idea was once got to formal balloting one vote per agency but participation in consensus building, show of hands etc could be with more people.
x. Richard: points out last line of email- 2 or more supporting member.
y. Dee: Now clear, thanks
z. Ron: Important if we're going to vote to have decided who the agencies are
aa. Maree: List available at door of of agencies thought to be part of the committee. Don't want to take up meeting with this issue, needs to pass that role onto Agencies. Agencies by this proposal need to re-nominate formembership
bb. Ron: who makes the selection?
cc. Maree: a political decision to an extent..
dd. Richard: issue for policy management.
ee. Maree: Inviting show of hands indicating level of consensus on motion hands
ff. *Motion Passed*

3.2 Presentation

[Richard: rather than all this below on the content of the presentation I suggest here a general statement such as: The consultant's presentation summarised the following issues addressed in more detail in the Stage 2 Consultation Report: Background – Review to date

Scope of Stage 2 Consultation
Options Paper - Scope
Options Paper – Contributions and deficiencies
Stage 2 Consultation Report
Model of legislation
What are the structural issues?
Using 'distinctions' to order provisions
How will the model be decided?
Structural distinctions identified in Stage 2

- By diagnosis – services argument
- By diagnosis – stigma argument
- By diagnosis – involuntary detention
- Positive and negative provisions
- By administrative arrangement
- By capacity (or its absence)
- Treatment need v risk of harm

Other structural issues
- Private sector
- Regulation of restrictive practices

Manipulating the matrix of distinctions to provide alternative models
What model is best for the ACT now?
What do we still need to know to factor the matrix of structural variables 'with diligence'?
Workability of current system
Forward process proposal]

Maree:

Page 1: Background, where we are up to.

P2a: Options paper should be based on discussion paper. Timeframe week before Christmas to Feb, extended to first week in March. Timeframe difficult, number of people away, really just had Feb. Spoke to a lot of people, in Appendix A of report. *Thanks everyone for assistance with coming up to speed.* A number of people didn't speak to and would like to, included individual tribunal members, psychiatrists, GPs generally, advocates. Written submissions, would encourage RAC members here to read.

P3a: Losing consultant was negative because didn't have anything besides the Options paper itself. Criticism of first area (definitions, principles)- confusion of issues and many issues significant to the definitions question were not raised. The definitions issue described in the Options paper produces 'fixity of vision'.

P3b: Focus for the presentation on issues that are about structure, leave the other issues aside for later. Need a picture of what the legislation should include.

P4a: Model of legislation- about structure of the whole area of law where a lot of interrelated laws. Clear a number of options for the structuring of legislation.

P4b: 'the definitions issue' doesn't describe the structure available to us. Mentions other Acts but disposal as too hard/complex and shouldn't consider. In consultations and submissions, views are to look at alternative models of legislation.

P5a: Other distinctions that have been raised besides mental disorder and no mental disorder. Do we draw distinctions or separate them?- creating concept or model of legislation.

P5b: distinctions between capacity and no capacity, public safety and autonomy. The government will choose in the end, policy of preferring certain distinctions and level of change desired- considerations.

P6a: distinction in terms of diagnosis for more appropriate response. Some suggesting need separate acts for diagnosis groups to encourage more appropriate response.

P6b: distinction in terms of diagnosis to reduce stigma.

P7a: distinguish between mental dysfunction and illness in terms of length of involuntary detention. May need to add short term (with mental dysfunction) and long term detention (reserving them for use with mental illness). Might need mandatory attendance for holistic programs that should take place in community.

P7b: narrow scope for involuntary provisions, and broad scope for protective provisions- suggested by a stakeholder should be in separate Acts.

P8a: Perception amongst service providers there is a great difference between disorder and dysfunction. Under current act, very similar provisions for each of the two groups, provisions essentially the same effect. Division is the authority of the chief psychiatrist and community care coordinator.

P8b: developing concepts nationally and internationally for capacity models- do or don't have mental capacity to provide informal consent to treatment. Puts voluntary treatment and importance of requesting concept right up front. Bring it back to a general health model- distinction between general health and mental health considered to be not relevant. If capacity preferred, then looking at Guardianship legislation, possibly in the extreme leading to the abolition of the Mental Health Act (first suggested by Rosenman) and just rely on Guardianship legislation. Other models that are less radical.

P9a: Risk of harm as a necessary condition in ACT not present in many other jurisdictions. Significant submission from psychiatrists in Sydney not arguing for capacity as principle consideration of new system- need to attempt clinical cultural change to look at best interests or treatment needs. Risk of harm a barrier for treatment. In ACT, have identified treatment need but also need a risk of harm- discriminating barrier for treatment. Unreliability of predicting risk of harm- argued the actuarial model demonstrated to be an unreliable predictor. Also without risk of harm criteria, can treat earlier and therefore may be more efficient.

Not something addressed in Options Paper but will need to consider.

P10a: (Regulation of/involvement of private sector) Nothing in current act that exclude private facilities from coverage in current Act. Problem- at the moment, treatment under Care coordinator and chief psychiatrist, who don't have any jurisdiction over private institutions. Seems to Maree the role of private care facilities will become greater, and something the government may seek to encourage. Development of private sector facilities, certainly for those under mental dysfunction where the specific treatment required. Do we want to engage those? And how to provide protection.

Another problem: everyone in a private care arrangement could be there illegally since a guardian cannot consent to treatment.

P10b: (Regulation of restrictive practice) eg excessive use of seclusion, physical and chemical restraint, need for regulation has been recognised.

P11a: various options are possible. *Option 2 addition to slides- mental incapacity act that deals with involuntary treatment for people without capacity.*

P11b: other variables that can provide alternatives.

P12b: didn't receive any submissions on the public safety issues, don't have information before us to assess how important the public safety issues are.

Trish: lack of information is the issue.

P13:

P14a: need to look harder at way PTOs and CCOs are used in the field. Need to ensure data one relying on is correct.

P14b: Focus principally on the structural issues now, once decide the model pursuing, then the other issues will fall out quickly.

P15a: Alternatives?

a) Proposal from Maree
b) *In favour of structural issues*

3.3 Forward process

[Richard: again this is interesting but arguably not suitable for minutes.. Suggest here that all resolutions simply be replicated.]

Model of Legislation

Maree: Proposal further actions

Matt: Preventative detention issue- could take away the word 'preventative'

Maree: Agree

Ron: Agree

Robyn: No submissions on public safety, could that be because there is another consultation of forensics

Maree: Yes, that needs to be addressed at the same time.

Richard: at the moment using 'mentally dysfunctional' not as in the definition- currently excludes mentally ill.

Ron: can we use another word?

Maree: population groups excluding mentally ill

Rom: question of capacity and incapacity, there is a definitional issue. Medical and legal approach different, not mentioned in the Act.

Maree: add to element in capacity- the identification of capacity is relevant. Not just clinically/judicially but what is it?

Motion approved

Maree: who is going to choose the model of legislation- working group in RAC, individual department, pursued interdepartmentally, consultant, submission to the committee from members, individual from here go and research. Suggest coordinator be Maree.

Motion approved

Public Safety Concerns

Maree: need idea about what public safety concerns are, need statistics on involvement of people with mental health issues in criminal justice system.

Ron: it may be there, David Bowles- JACS committee. And AIC under Tony M, there is research there.

Robyn: *addition to slides* number of defendants referred to mental health tribunal who are charged.

Ron: those figures are available.

Nicole: Don't gather certain data- caveat. If get true picture, would have to identify types of violent crime want to look at, then manually go through files.

Ron: most would be caught by referrals but not all.

Peggy: not sure why the violent crime focus is needed.

Maree: suggestion lose reference to violence, and looking at crime in general.

David P: Whether complicating the issue, in relation to crime, wouldn't it be easier to ask the Institution of Criminology, rather than to do primary research ourselves.

Maree: local knowledge needed?
David P: don't know if will get answers.

David L: Need a broader understanding of public safety. Should be broader including safety concerns in terms of crisis service provision, not just crime.

Simon: can investigate relation between crime and mental health but does not necessary have relation to public perception. These are two different issues.

Robyn: who is actually at risk? There are specific populations, in particular families and carers. There are particular areas where particular populations have views about what they need.

Maree: trends in risks to public safety may be better, may not be specifically violent crime.

Ron: The AFP is not represented today. Feel the AFP may have statistics on crime, and crime that is not chargeable in the end.

Maree: keeping it broad, exact detail remains to be decided.

Maree: in favour of further investigation?

Motion approved?

Maree: consultant or AFP?

Nicole: AFP will have limited information.

Ron: might just want to have a simple investigation, marking files with mentally ill.

Maree: who should do this work?

David 2: A job for the consultant

Nicole: something that needs to be coordinated by JACS.

Matt: if waited for forensics options paper to come…

Maree: it may be too late.

Maree: proposing forensics paper resolved in the same time frame as this one, and so later all have a look.

Maree: JACS preparing paper?

Motion approved?

David 1: could others also make submissions?

Maree: could JACS coordinate these submissions?

General agreement with that

Ron: aren't we collecting empirical material?

Private sector regulation

Maree: whether need to look into the issue now or too difficult?

Ron: clients should have the choice of who to see but the lack of case management in the private sector is worrying.

Peggy: has to be addressed.

Maree: might be the need for further discussion as to the extend. Perhaps we need to look at the need for it.

Ron: need to look at definition of 'informed consent'

Maree: In favour of including an investigation into need for integration of private care arrangements.

Motion approved.

Maree: Time issues

Agreement that we will role through the issues

Regulation of restrictive practices

Motion approved

Maree volunteers

Trish: Public Advocates happy to be involved in that.

Outline of possible models

Motion approved

Maree's responsibility

Research into Act usage

Trish: yes, should do this because.

Maree: who would like idea should know more about it and get more data

Ron: why not only look at emergency ones only?

Maree: to make the issue smaller.

Delete non-emergency and details

Peggy: to make it relevant, would have to look at whether the PTO's should have been CCO's etc.

Maree: agree. But if moving forward, is it relevant to discuss whether right/wrong.

Ron: needs to be information, so people can appreciate what actually happens.

Peggy: what make of the information would be limited.

Maree: wish to investigate, uncertain into who/what.

Motion approved

Forensics Paper

Maree: take Richard's point that unless the forensics paper is not coordinated with the rest then can throw everything out. Suggestion the completion be parallel to the MHA reform.

Nicole: change aim rather than instruct.

Maree: *that the committee request the completion.*

Motion approved to resolve forensics paper at a similar time

Statements of policy

Maree: to gain an overall picture, and to prove acted with due diligence, understand there is no consolidated view of JACS.

Dee: important know where starting from.

Richard: Waiting for the significant recommendations to come from this group.

Nicole: the recommendations comes from this group.

Barry: important that individual departments are looking at what their positions are

Sid: maybe want a directional statement about what the policy teams will actually consider.

Robyn: a bit restrictive and against the minister's requirement for open process. If restrict the policy options first.

Ron: may as well know about the resource limitations before we start.

Maree: ask the government to look at the issues currently on the table and the extent to which they are prepared to do, or leave the issue?

Motion approved to look at this in the future.

Community authorise consultation within the committee

Statements of policy removed

Maree: committee consultation with the committee or need to go back to the community?

Nicole: would need ministerial community.

Ron: push on.

Maree: consult with respective constituencies?

Maree: include submissions from Bar association/legal community about model of legislation, they could be interested this time.

Nicole: still need Ministerial approval.

Sid: could simply invite them to the RAC.

Ron: Martin is involved in the Bar association here.

Maree: if keep it within the committee, doesn't exclude members from seeking views.

Maree: proceed within the committee only?

Luke: with the caveat of looking at something maybe different later on.

Majority approves within the committee

Substantial Dissenting view: opportunity should be there.

Maree: greater restrictions placed on public consultation?

Maree: after consultation within own organisations, then decide what we need to do further.

Approval for this middle ground.

Completion of stage 2

Approval Maree complete consultation process

Report on 'new stage 3'

Approved

Additional

Maree: in terms of next meeting, do you want to set up a monthly thing or see the paper first?

Agreement to see papers first

Sid: recommendation 27 is a structural issue (whether we need certain sections for young people or not)

Maree: doesn't affect the model. Need to work out whether to separate the other sections of the Act.

Richard: not structural in term of the model itself.

Maree: information for next meeting?

Richard: rolling set of one month meeting?

Maree: They want to have the paper first. Maree would like at least 6 weeks.

Ron & Maree: 2 months?

Agreed, 2 months from today.

DRAFT

ACT Health

Mental Health (Treatment and Care) Act 1994
Review

Review Advisory Committee (RAC)

16 APRIL 2008
Minutes
9am - 12am, Training Room, Level 1, 1 Moore St

1. Introduction

Richard Bromhead: Acting Chair & ACT Health

2. Attendance

Sue Watson, Disability ACT; Robyn Holder, Victims of Crime Coordinator; Belinda Barnard, Matt Hingston, Human Rights Commission, Dawn Roberts, ACTDGP; Simon Vireck, David Lovegrove ACTMHCN; Dee McGrath, Carers ACT; Dr Peggy Brown, ACT Chief Psychiatrist; David Plant, Barry Petrovski, MHCC of ACT; Michael Chilcott, DPP; Christina Thompson, Trish Mackey, Sue Hockley Office of the Public Advocate; Nicole Mayo, JaCS; Ron Cahill, ACT MH Tribunal; Toni Hunt act Corrective Services; Angela Greensill MHACT; Jenny Thompson RANZCP; Michael Edwards, Libby Trickett ACT Law Courts; Sid Chakrabarti Youth Coalition; Luke McAlary CMD; Martin Hockridge, ACT Legal Aid Office.

3. Apologies

Ross O'Donoughue ACT Health Chair RAC; Victor Martin JaCS; Andrew Whale Disability ACT; Janelle Reading ACT Care Coordinator; Sue Connor, Mental Health Principle Official Visitor, Herb Krueger ACMHN

Maree: Copies of Aequitas Report and Written submissions available for members of the RAC to take.

Richard: We don't have explicit permission for the submissions to be made public. We request that only the RAC representatives currently here have access to the papers.

4. New business

Maree: Been a year since the last committee, new people. The review can be seen as restarting from this position. Wish of the secretariat, and Maree's intention, *to establish a way forward*. At a point where there has been an untidy development of various issues (some more ahead than others) and people who have been consulted (not everyone has been). Moving to the point where need to make recommendations, tidy up process of decision-making.

a) Have a look at decision-making process of RAC, in the next 15 minutes.

b) Give a presentation in relation to the report. Not going to summarise the whole report, will focus on process- direction needed for further work.

If we could, have discussion in the second part of the meeting.

Should be out of here by 15min to 12.

Michael 1 (DPP): what is the forward timeframe for this process. My understanding is there should be a Bill in place now. What are we aiming for?

Maree: depends on what your views are at the end of the forum. The Minister of Health doesn't think we should rush the decision. No pressure, but do need a forward program.

Richard: Probably December 2009.

4.1 Decision making process

Slide: proposal for RAC decision-making.

Richard: (speaking to proposal): Essentially a response from people consulted, this is a working through implications if decision could not be reached. Resort to alternative to consensus only as a last resort. Proposed we looked at a balloting system if the RAC could not arrive at consensus. Experience of previous RAC meetings was there was fluidity in representatives and some organisations had more than one person here but if come to a balloting, how do we sort through that?

Maree:

- Basic proposal relies on deciding who is in the committee and who is not. People go back to agencies and to renominate their representative. Need to do this afresh.
- That all the representatives that appear at the RAC have authority to vote.
- Decision by consensus remains the primary way of decision-making.

RAC Discussion Summary: reflected the need to prioritise the RAC processes for consensus and that a show of hands helped the consensus process by indicating positions that could either be agreed or in need of further discussion, and that formal balloting was only a last resort if consensus not achieved. Dissenting views would be recorded not by number but 'significance' or strength of dissent.

Agencies requested to nominate a representative and a proxy, the representative or proxy if required would vote in the Ballot if one was required one vote per agency but participation in consensus building, show of hands etc could be with more people.

Ron: Important if we're going to vote to have decided who the agencies are

Maree: List available at door of agencies thought to be part of the committee. Don't want to take up meeting with this issue, needs to pass that role onto Agencies. Agencies by this proposal need to re-nominate for membership.

- Maree: Inviting show of hands indicating level of consensus on motion hands

For all Resolutions refer to Resolutions paper attachment to the Minutes

4.2 Presentation

Richard: rather than all this below on the content of the presentation I suggest here a general statement such as: The consultant's presentation summarised the following issues addressed in more detail in the Stage 2 Consultation Report:

- Background – Review to date:
- Scope of Stage 2 Consultation
- Options Paper - Scope
- Options Paper – Contributions and deficiencies
- Stage 2 Consultation Report
- Model of legislation
- What are the structural issues?
- Using 'distinctions' to order provisions
- How will the model be decided?
- Structural distinctions identified in Stage 2
- By diagnosis – services argument
- By diagnosis – stigma argument
- By diagnosis – involuntary detention
- Positive and negative provisions
- By administrative arrangement
- By capacity (or its absence)
- Treatment need v risk of harm
- Other structural issues
- Private sector
- Regulation of restrictive practices
- Manipulating the matrix of distinctions to provide alternative models
- What model is best for the ACT now?
- What do we still need to know to factor the matrix of structural variables 'with diligence'?
- Workability of current system
- Forward process proposal]

4.3 Forward process

Richard: again this is interesting but arguably not suitable for minutes.. Suggest here that all resolutions simply be replicated.

4.3.1 Model of Legislation

The question of capacity and incapacity, there is a definitional issue. Medical and legal approach different, not mentioned in the Act. - add to element in capacity- the identification of capacity is relevant. Not just clinically/judicially but what is it?

Motion approved

Maree: who is going to choose the model of legislation- working group in RAC, individual department, pursued interdepartmentally, consultant, submission to the committee from members, individual from here go and research. Suggest coordinator be Maree.

Motion approved

4.3.2 Public Safety Concerns

Maree: need idea about what public safety concerns are, need statistics on involvement of people with mental health issues in criminal justice system.

Recommend discussion with David Bowles- JACS committee. And AIC under Tony M, there is research there.

Concern raised that need a broader understanding of public safety. Should be broader including safety concerns in terms of crisis service provision, not just crime.

Maree: in favour of further investigation?

Motion approved?

Maree: could JACS coordinate these submissions?

General agreement with that

4.3.3 Private sector regulation

Maree: In favour of including an investigation into need for integration of private care arrangements.

Motion approved.

Agreement that we will role through the issues

4.3.4 Regulation of restrictive practices

Motion approved

Trish: Public Advocates happy to be involved in that.

4.3.5 Outline of possible models

Motion approved

Maree's responsibility

4.3.6 Research into Act usage

Ron: why not only look at emergency ones only?

Maree: to make the issue smaller.

Delete non-emergency and details
- to make it relevant, would have to look at whether the PTO's should have been CCO's etc.
Motion approved

4.3.7 Forensics Paper

Maree: take Richard's point that unless the forensics paper is not coordinated with the rest then can throw everything out. Suggestion the completion be parallel to the MHA reform.

Maree: *that the committee request the completion.*

Motion approved to resolve forensics paper at a similar time

4.3.8 Statements of policy from Government

Maree: to gain an overall picture, and to prove acted with due diligence, understand there is no consolidated view of JACS.

Richard: Waiting for the significant recommendations to come from this group.

Motion approved to look at this in the future.

4.3.9 Community authorise consultation within the committee

Statements of policy removed

Maree: committee consultation with the committee or need to go back to the community?

Nicole: Going back to the community would need ministerial approval.

Maree: proceed within the committee only?

Luke: with the caveat of looking at something maybe different later on.

Majority approves within the committee

Substantial Dissenting view: opportunity should be there.

Approval for this middle ground.

4.3.10 Completion of stage 2

Approval Maree complete consultation process

4.3.11 Report on 'new stage 3'

Approved

5. Additional

Maree: in terms of next meeting, do you want to set up a monthly thing or see the paper first?

Agreement to see papers first

Agreed, 2 months from today (mid- June 2008).

T.B.A.

RESOLUTIONS

REVIEW ADVISORY COMMITTEE MEETING

16 April 2008

1. Meeting process

RESOLVED:

- That agencies re-renominate their RAC membership, their representative and a proxy.
- That representatives should have the authority to commit their agency to views or recommendations.
- That 'decision-making by consensus' remain the primary mode.
- That where consensus is not possible, a ballot of the RAC would take place with the view to put forward "recommendations without consensus". The ballot would be limited to one member per agency.
- In the event that a ballot reveals a significant dissenting position that the terms of that position will be recorded.

2. Forward process

RESOLVED:

- That the focus of immediate forward action should be to facilitate RAC capability to make recommendations, with due diligence, in relation to a model of legislation at the earliest possible time.

3. Model of legislation paper (1)

RESOLVED

The Committee authorises further investigation and report on:

- schemes for involuntary interventions in place in other jurisdictions;
- rationale for detention of population groups not including mentally ill, in the ACT;
- the identification of capacity and workability of a distinction between capacity and incapacity a structural element; and
- best interests v risk of harm criteria for involuntary orders.

Action option selected:

- Consultant to investigate and report

4. Public safety trends

RESOLVED:

- That the Model of Legislation paper include investigation and summary of attitudes to public safety in the ACT, trends in risks to public safety, and the relationship between these risks and the mental health of offenders, including the number of offenders referred to the Mental Health Tribunal.

- Action option selected:
  - JACS to manage (including, but not limited to, receipt of submissions)

5. Private sector regulation

RESOLVED:

- That the Model of Legislation paper address the need for additional investigation into integration of private care arrangements for persons with mental illness or mental dysfunction within the ACT

6. Regulation of restrictive practices

RESOLVED:

- That the Model of Legislation paper address possible mechanisms for regulating restrictive practices (seclusion, physical restraint, chemical restraint) in the care of people with mental illness and mental dysfunction

7. Outline of possible models

RESOLVED:

- That the Model of Legislation paper includes a summary of the possible models of legislation arising from employing and preferring various combinations of the distinctions in legislative structure

8. Research into Act usage

RESOLVED:

- That research be conducted to isolate basic demographic data related to PTOs, CCOs and restriction orders granted over the most recent 12 month period (to be reported within the Model of Legislation paper).
- Action option selected: Courts and Tribunals to conduct

9. Forensics paper

RESOLVED:

- That the Committee request completion of the detailed report on options for forensic provisions (the Forensics paper in coordination with the preparation and delivery of the additional material in relation to the Models of legislation paper.

10. Statements of policy

MOTION – deferred for further consideration

- That ACT Mental Health and JaCS be requested to provide statements of policy in relation to issues subject to consultation in the Review.

11. New Stage 3 consultation

Resolved:

- That the Committee authorises consultation within the Committee for the time being with further possibility of greater consultation in relation to the Models of Legislation paper and the Forensics Paper.

12. Completion of Stage 2 consultation

RESOLVED:

- That the Review specifically invite psychiatrists, GPs and individual tribunal members to make submissions in response to the issues represented in the Options Paper during the proposed new Stage 3 consultation period.

13. Report on 'new Stage 3'

RESOLVED:

- Authorising preparation of a report summarising consultation on:
  - the Models of Legislation paper
  - the Forensics paper
  - completion of Options Paper consultation

+ a revised proposal for 'forward process'

Mental Health (Treatment and Care) Act 1994 Review

Review Advisory Committee

9:30am – 12:30pm, Level 1, Training Room, 1 Moore Street, Civic

Chair Agenda

10 December 2008

9:30 Open and intro: Chair Ross O'Donoughue

Apologies:

Previous Minutes: (16 April 08)

New Business

9:45 Presentation – Model of Legislation paper: Consultant -Maree Livermore

10:15 Questions/discussion

10:40 Morning Tea

11:00 Presentation – Forensic Mental Health Options Paper: Victor Martin

11:30 Questions/Discussion

11:45 Forward Process -- Maree Livermore

12:00 Business arising/further discussion: Maree Livermore

12:30 Close: Ross O'Donoughue

DRAFT

Mental Health (Treatment and Care) Act 1994 Review

Review Advisory Committee (RAC)

10th December 2008

Minutes

9:30am – 12:30pm, Level 1, Training Room, 1 Moore Street, Civic

1. Introduction

Ross O'Donoghue ACT Health Chair RAC

2. Attendance

Ron Cahill ACT, MH Tribunal; Sid Chakrabarti, Youth Coalition; Dr Peggy Brown, ACT Chief Psychiatrist; Trish Mackey, Christina Thompson, Denise Caldwell, Office of the Public Advocate; Jenny Thompson, RANZCP; Victor Martin, Sean Moysey, JaCS; David Lovegrove, Simon Viereck, ACTMHCN; Herb Krueger ACMHN; Sue Watson, Disability ACT; Martin Hockridge, ACT Legal Aid Office; Michael Edwards, ACT Law Courts; Matt Hingston, Human Rights Commission; Deb Merritt, MHACT; Martin Thomas, MHCC; Robyn Holder, Victims of Crime Coordinator; Annemarie Ashton, Carers ACT; Richard Bromhead, ACT Health; Ross O'Donoughue, ACT Health; Maree Livermore, AEQUITAS. Scribes: Sarah Colman and Suhanniya, AEQUITAS.

3. Apologies

Ross O' Donoughue, ACT Health, Chair RAC

4. New Business

(a) Presentation- Model of Legislation Paper: Consultant – Maree Livermore.

(b) Questions/ Discussion – Model of Legislation presentation

The Chair facilitated questions and discussion in four sections:

(i) Role under the MHA of non-government service providers and private practitioners.

Richard: There are a number of questions. Firstly, in regard to regulation or non-regulation in community services providing social support, perhaps more specifically for residential support, for services covering both mental illness and mental dysfunction: Secondly, in relation to the role of the

chief psychiatrist - in other states the office of the chief psychiatrist has more of an oversight, regulatory role. Thirdly, how do we pick up private practitioners?

Ron: There's the problem that the guardianship act has no coercive power.

Peggy: Interested in examining differences in issues between treatment and care.

(ii) Capacity

Victor: We should be aware that the litigation of capacity issues in guardianship jurisdiction has in certain cases involved expensive legal representation and clinical assessment.

Maree: The mode of assessment of capacity, in all the relevant contexts, is an important issue under capacity models. Where issue involves a lot of money, there may still be 'lawyers at ten paces' and expensive clinical assessment.

Sid: Capacity isn't really defined in Australia. Needs more cases to go through the courts.

Maree: We also need legislation to explicitly define capacity. Legislation will provide more consistent parameters.

Richard: I recommend the NSW Attorney General Department's 'capacity tool kit', very good discussion using common language, aimed at clinical carers and consumers affected by mental health issues.

Maree: Note also that when the UK introduced its new Mental Capacity Act that an extensive companion code of practice was attached to the Act – user-friendly, plain English guide to the way principles should be applied to capacity in various contexts. If we proceeded in a capacity direction, we would need to develop sets of standards or code of practice.

Ron: Tool kit is an excellent idea, in this area people are needing to make daily decisions about capacity. Decision makers are currently not working via definitions. It is essential to attempt to define capacity in the legislation.

Sean: Issue is about capacity in context. The police use a different threshold to exercising capacity in long term situations and coercive situations. There needs to be a benchmark, but it also need to be clear about the contextual nature.

Maree: Under new approaches to capacity it is the decision-specific element - capacity in relation to the particular decision - that is important.

Sean: On coercive powers - irrrespective of the judgement calls, there is a strong practical and human rights requirement to ensure that the sources of coercive power are accountable - whether that deals with government, tribunal or other judiciary bodies. I want a clear distinction between tranquil issues and coercive issues. What inherently involves coercive activity? Who makes the decision and who carries it out?

Peggy: To enable treatment or to require treatment to be given doesn't necessarily require coercion to occur. Some coercion may be needed but depends on how we currently perceive these issues.

Maree: 'You must have treatment'- isn't that in its nature coercive?

Peggy: Depends on the response of the individual

Sid: At the common law, it was never envisaged that other than clinicians that were making these decisions. We commissioned Mallesons to look into the young people's Act; there is lots of uncertainty, the issue becomes consistency between states and territories and consistency generally.

Peggy: Clinicians would need to know how to apply capacity criteria. Otherwise the immediate determination of "what should I do right now" when the patient appears for treatment, perhaps after an emergency apprehension, may become a dilemma for the clinician.

Victor: Would some individuals avoid the ACT to avoid treatment, because of differential regime?

Ron: Peggy raised an important question. Taking people in and actually prescribing treatment are two separate issues.

Peggy: During transport, paramedics already have the power of treatment

Ron: What is necessary to protect life and safety?

Deb: This has an effect on future treatment.

Ron: It's not anything that people will consent to.

Maree: Its not about consent or capacity at the point of an emergency. Capacity models don't remove scope for emergency attention. It doesn't change the range of issues and powers we already have (although the ambulance issue has not been properly addressed).

(iii) Restrictive practices and (iv) risk of harm

Richard: Attended symposium of Centre for Law and Medical Ethics (University of Sydney) with Deb and Maree. Presentation of psychiatrists indicates presence of risk of harm as a criterion in Mental Health Acts delays treatment by 2-5 years. Early intervention is important.

Deb: Everyone would like early intervention, but clinicians can be unpredictable.

Robyn: I think it is important to have separate focus on risk of harm for self as opposed to others, useful also to look at what the risk of harm question is meant to lead to. Peggy's distinction between treatment and care might be useful to her. Risk of harm to others is mainly a care issue about what is happening around that person, less of an issue about treatment, more a framework to enable appropriate disclosure of information, appropriate care management enables a framework. The discourse around risk has enabled a broader framework of a range of interests to be considered.

Sean: Risk of harm notion is a big notion that needs to be unpacked; we need clear distinctions between therapeutic stetting and forensic setting. Polarising the two makes it clearer. What is the *behaviour* for a criminal justice point of view? The Model paper touches on issues more directly related to the criminal justice sector, though it has a relationship to forensic mental health sector. There are new preventive detention laws passed in Queensland, tested in the *Farden* case, representing principles tested in the European Human Rights Court. In terms of preventative detention, the issues are what is the threshold, what is the criteria, what is the risks - all hot issues. There will be people in the mental health jurisdiction who will fit in the category for a form of preventive detention and those who don't. Analysis on how they would fit is needed. It is useful to look at European cases about forensic health issues. Dangerous criminal offender legislation is a separate set of issues.

Maree: There is some overlap.

Sean: Yes and it is not spoken about clearly and we need to do that.

Deb: Very often mental health services risk assessment makes for more aggression. The need to look at risk clouds the picture and affects recovery.

(c) Presentation- Forensic Mental Health Options Paper: Victor Martin, JaCS

(d) Questions and discussion – Forensic paper

Re possible victims provisions

David: Insertion of victims provisions may harden a polarised adversarial view between victim and consumer. Couldn't we resolve this in a more restorative justice sense?

Robyn: Exclusion increases polarisation. Controlled process for more voices to be heard provides for de-escalation. Views are not punitive. Mediation or a restorative approach has a different focus - on care and treatment of the person. The processes under discussion have broader purpose.

Sean: The restorative justice model requires the person to take responsibility. Response is far more positive, constructive outcome and addresses a need that cannot be addressed in current adversarial system. Media perception that inherently victim and offender are always going to be adversarial.

Robyn: Inclusive and early response and acknowledgement mitigate worst impact of traumatic impact.

Richard: Victims that feel they are being believed is important.

Re arrangement of options paper

Sid: Hard for the layman to understand to understand the options summary without looking at the introduction – perhaps move options to a position after the Intro. Gist of page 14 should be placed in the introduction. We should be able to read from start to end of the paper, fully understanding.

(e) Forward Process

Maree: What do people think about the end of January as a viable date for the end of consultation on these papers?

General Consensus: This is a largely optimistic hope.

Victor: Propose we need another 4 weeks till the end of Feb. Full blown community consultation not desirable. Papers are highly technical; we won't obtain the type of feedback that we need. An alternative: putting document on departmental websites and targetting specific groups. Not presenting it to community at large in February. Need to ask ministerial permission to post the papers.

David: Found this dialogue very useful. Would like to continue this process for at least 2 more sessions.

Maree: Is the options paper now in a form where it can be publicly released for targeted consultation or do we need additional discussion?

Sean: David, are you suggesting we need more time to ready the paper?

David: Yes, need more time to further the fruits of process.

General Consensus: 10 members of panel feel that the paper is ready to come out of the forum and go to targeted consultation.

Robyn: Concern that we're going around in circles with more work on the paper – paper has been in preparation by specialist group for 6 months.

Peggy: There are some very complex ideas raised in it though that some parties here in the RAC are better placed to discuss. I wonder if there is an intermediate step we could take to help members of this group and better prepare them for wider discussion.

Deb and David: Consumer input (forensic consumers) quite important

Peggy: Propose a February a forum.

General Consensus: 2nd Week of Feb.

Ross: Summarised view of meeting that there should be a facilitated / preparatory workshop on forensic paper in 2nd week of Feb with a fuller consultation process after that.

(f) Model of Legislation paper - forward process.

Maree: Do we need a second forum for the model of legislation paper?

Trish: There is a lot in it. Need more discussion and time to come to terms with the issues properly.

Richard: It is the role of the RAC to come to a decision on the model of the legislation. We don't need to go out for public consultation on that. There will enough opportunity for public consultation on the draft legislation. That is where have to get to next.

Ross: It is for the RAC to put options before the Government.

Peggy: Several RAC members represent groups. They need to verify their constituent interests to give the most informed contribution as the next RAC meeting. This is difficult given the confidentiality of the current level of discussion.

Anne-Marie: We will not be circulating paper to our members. We will be pulling out a few key questions.

Ross: Need to determine the focus of our targeted audience.

Richard: Suggests RAC in March on forensic paper and Model of Legislation paper.

Maree: Suggest February workshop on model of legislation issues with individual consultations, presentations for those interested after.

5. Meeting Close – Ross O'Donoghue

Mental Health (Treatment and Care) Act 1994 Review
Review Advisory Committee

Wednesday 24 March 2010
9.30am – 12.30pm
Level 1, Meeting Room 6, Griffin Centre,
Genge St, Canberra City

Agenda

Chair: Ross O'Donoughue

Apologies:

New Business:

Introduction: Ross

Presentation and discussion – *Forensic Mental Health Options Paper* - Victor Martin, Department of Justice and Community Safety

Presentation – *The Framework of Mental Health and related Legislation in the ACT: Consultation Report* - Review Consultant, Maree Livermore

Morning Tea

Discussion and questions: Facilitated by Ross O'Donoughue and Maree Livermore

Forward Process - Ross

Meeting Close

FRAMEWORK OF MENTAL HEALTH AND RELATED LEGISLATION IN THE ACT.

Stage 3 Consultation Report to the RAC

NOTES TO RAC PRESENTATION

All page references below relate to Consultation Report

Definition of Mental Capacity

'Stakeholders were generally supportive of the concept of development of a standardised definition of mental capacity whilst cautious about aspects of the sample definition proposed, and looking for more information and detail about how the definition would be used. In the absence of a decided Framework, it was clearly difficult for stakeholders to imagine the effect of a capacity test in view of the range of legislative criteria, processes, principles and purposes that might potentially apply alongside it...'

'There was an overall sentiment that the concept needed more detail and explanation before stakeholders would feel confident about the particular form of definition proposed...' (Pg 3)

Placement of Mental Dysfunction Provisions

'... three submissions expressly supported retention of the mental dysfunction provisions in mental health legislation. No submission supported their complete removal. Seven submissions expressly supported 'fusion' legislation (the combination of a mental health and mental capacity or guardianship provisions in the one law. One stakeholder suggested a new alternative being retention of such of the mental dysfunction provisions as would be appropriate in an Act pertaining only to those who would receive clinical benefit from 'mental health treatment' (which would include those with mental dysfunction conditions who benefit from 'psychiatric' medication and other therapies). Another stakeholder did not express a clear preference for 'fusion' legislation overall but did suggest that the specific issue of placement of mental dysfunction conditions might be best addressed by 'fusion' legislation...' (Pg 8.)

Coercive powers in guardianship

'On balance, the majority of responding stakeholders supported the creation of coercive provisions in guardianship on the condition of a high level of formal oversight. These stakeholders included consumers, carers and clinicians.'

For

'....There was, rather, a simple acknowledgement that coercion was needed in specific situations from time to time, and exercised in any case without regulation other than the rather indistinct common law that currently applies.' (Pg10)

Against

'...the addition of coercive powers under guardianship would broaden the range of contexts in which persons with impaired mental capacity could be subject to directed action against their preference. There is some concern about the impact of this, particularly in relation to disability consumers.

'...duty of care powers for service providers are currently sufficient to provide a legal basis for coercive action...'

'...the community does not want guardians, only attorneys appointed by the consumer, to have coercive powers.' (Pg 11)

Restrictive Practices

'Stakeholders appeared to be more comfortable approaching the coercive power issue in the context of restrictive practices...'

'Seven responses supported additional regulation of restrictive practices. Two maintained that current protections were sufficient....'

'The common law is not sufficient – 'the use of such practices requires the need for guidelines which are linked to legislation to provide standards, protocols and practices.' Pg 14

Contrary view: common law is sufficient.

Option A: Retain current arrangement

'Two respondents expressed explicit preference for Framework Option A with three other respondents implying their support for the Option.' (pg 16)

Option A + capacity criterion

Three approaches suggested:

- 'Give greater prominence to a mental capacity criterion within the existing 'risk of harm' and diagnosis-based framework.
- 'Replacement of the harm-based criteria with capacity criteria .....as a 'first step in on-going reform.''
- 'Replacement of the harm-based criteria with three 'preconditions' ...namely: [no capacity even with support; clinical benefit from mh treatment; and best interests]' (Pg 18)

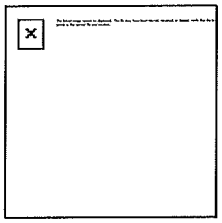
Option B: Alternative placement of 'mental dysfunction' provisions

'Option B was the least supported of the options proposed. Those who favour retention of the current form of the Act appeared to unanimously support its continued application to people with both mental dysfunction and mental illness conditions. Stakeholders favouring departure from the current scheme tended to favour Option C (under which the distinction between types of consumers would disappear).' (Pg 19.)

Option C: A mental capacity law

'Seven stakeholders making written submissions expressly supported Option C. In an eighth submission, a clear preference was not stated but it was put that Option C appeared to solve difficulties identified as relevant to the stakeholder.'

'Another stakeholder supported much of the conceptualisation of Option C but had concerns about its application across the board, preferring, in the first instance at least, a capacity-based mental health law.' (Pg 20.)



Mental Health (Treatment and Care) Act 1994 Review
Review Advisory Committee

Wednesday 24 March 2010

Meeting Report

1. Present:

Ross O'Donoughue (Policy Division, ACT Health)
Trish Mackey (Public Advocate, JaCS)
Sarah Byrne (A/g Public Advocate, JaCS)
Denise Caldwell (A/g Public Advocate, JaCS)
Richard Bromhead (MHPU)
Matt Hingston (Human Rights Commission)
Sean Costello (HRC)
Sue Watson (Disability ACT)
Lesa Gale (AFP)
Renate Moore (CMD)
Brooke McKail (Mental Health Community Coalition)
Simon Viereck (MHCC)
Claire Carpenter (Carers ACT)
Cathy Fox (Consumer Rep, MHACT)
Greg Tong (Corrective Services, JaCS)
Hugh Jorgensen (ACT Magistrates Court)
Libby Trickett (ACT Supreme Court)
Dalane Drexler (Observer, ACT Mental Health Consumer Network,)
David Lovegrove (ACT MHCN),
Linda Crebbin (ACT Civil and Administrative Tribunal)
Maree Livermore (Review Consultant)
Victor Martin (Criminal Law, JaCS)
Beck Dawson (Secretariat, MHPU)
Velda Hunter (Secretariat, MHPU)

2. Apologies:

Rosemary Agnew (ACTDGP)
Tina Bracher (Community Health/Care Coordinator, ACT Health)
Sue Connor (Principle Official Visitor, MHACT)
Mary Durkin (Health Services Commissioner, JaCS)
Margaret Ford (Victims of Crime, JaCS)
Toni Hunt (Corrective Services, JaCS)
William Kerley (Carer representative - Carers ACT)
Peter Marshall (Corrective Services, JaCS)
Nicole Mayo (Legislation and Policy Branch, JaCS)
Dr Peter Norrie (MHACT)
Andrew Whale (Disability ACT, DHCS)

3. Introduction by Chair, Ross O'Donoughue

The purpose of the meeting was to discuss the *Forensic Mental Health Options Paper* and to present the outcomes of the community consultation on The *Framework of Mental Health and Related Legislation in the ACT: An Options Paper.* Consultations on these documents ran from November 2009 to January 2010; and the date for receiving submissions was extended.

Following on from this meeting, the intention is to provide Cabinet with a series of options for a way forward to update the legislation.

4. Presentation and discussion – *Forensic Mental Health Options Paper* - Victor Martin, Department of Justice and Community Safety

The *Forensic Mental Health Options Paper* was developed as a result of concerns related to the treatment and services that are available to mental health consumers in the criminal justice system. A review that was conducted in 2007 brought to light the complexity of issues, including those associated with the development of a secure mental health facility.

Five submissions from the community consultation were received. Please see Attachment A for the Summary of Submissions, copies of which was tabled for RAC members.

The consultation indentified some polarised views:

- There was broad support for the courts retaining decision-making capabilities related to fitness to plea, and support for ongoing review of care, and review of forensic arrangements.
- Presentation and access to information by victims, courts, carers and General Practitioners raised specific considerations.
- Most discussion and differing views were regarding information sharing, particularly in relation to victim's rights. The overwhelming view was the way the law should be structured - not doing away with the rights of the forensic detainees, but to weigh the need for victims or agencies to have access to information.
- Issues of victim's rights in relation to appearances at forensic proceedings was raised, and the difficulties in the crafting of decisions by the tribunal when victims do have to appear.
- The sharing of information regarding a person's treatment or care should be very carefully scrutinised before decisions are made about how or if information is shared. It may not be appropriate for information to be provided to a victim.
- The provision of any information has to be carefully considered by the decision maker, not just a 'fait accompli' in the law.

- A further concern was raised regarding the courts achieving a limited term for a court to place on a person in detention.
- Consideration of options for community-based care for forensic clients was raised.
- There was support for forensic capabilities to be retained in the Mental Health Act, as separation of legislation for forensics would be disruptive and make the work of the tribunal more difficult.
- However, should it be resolved to bypass the tribunal system, then separate legislation may be justified but overarching legislation for decision making is needed. It is inappropriate for the tribunal as the decision-making body to make these recommendations.
- The consultation process and outcomes of this meeting need to be followed up with another meeting to enable discussion and clarification of fine details regarding the options.
- The small number of specific court lists that deal with the low numbers of forensic mental health cases in the ACT as a small jurisdiction requires further consideration, with engagement with the courts and related elements of the criminal justice system to resolve issues.

5. Presentation – *The Framework of Mental Health and related Legislation in the ACT: Consultation Report* - Review Consultant, Maree Livermore

Acknowledgement was given to the late Michael Firestone for his contribution to the review and the consultation process. Thanks were also given to those who submitted responses. The RAC was reminded that submissions were available on the web.

Ms Livermore presented a verbal report on the consultation submissions in relation to the three options that were posed in *The Framework of Mental Health and related Legislation in the ACT: An Options Paper.*

Option A - Keeping the current structure

There were two submissions in support and three that implied support for this option. The views expressed either were strongly for the risk of harm criteria, or strongly opposed to it.

ADACAS, proposed that capacity be added to Option A, and that the Act be redrafted to include the requirement for the need for clinical benefit. This option also arose in other ways.

Other ways that this was suggested was through the factoring in of capacity criteria, thus bringing it forward more strongly in current arrangements.

Option B – Current arrangement of the law, but with mental dysfunction removed form mental health law.

This was the least supported of the options proposed.

It was posed that if other stakeholders, for example the disability sector, were involved there may have been a different outcome.

Option C – Introduce a capacity-based law

There were seven submissions supporting this option, though some were with specific qualifications, for example '... but only if...'

There were concerns raised regarding how the option would work, and who would be covered, however, more work would be required to tease out the practical terms.

6. **Discussion and questions: Facilitated by Ross O'Donoughue and Maree Livermore**

Mental Dysfunction

Three submissions expressed support for the retention of mental dysfunction in the Act, seven supported fusion models of legislation. None supported complete removal of the definition.

Coercive Powers

There was support expressed for the creation of some form of power within the guardianship scheme for action that may not be in line with the will of the consumer. Longer term deprivation of liberty or intervention is not covered by the Common Law. The Bournewood case that highlighted deprivation of liberty (UK) has not been tested explicitly in Australia.

Case Studies

There was a suggestion to consider hypothetical examples (case studies) to enable consideration of how legislative changes might work from the viewpoints of the Tribunal, Mental Health ACT, The Public Advocate, the courts, and consumers.

Engagement with Disability and Aged Care Sectors

Concern was expressed regarding engagement with the disability and aged care sectors. The RAC was informed that Disability ACT has been engaged since the commencement of the Review, and there was engagement with aged, disability, and service providers who attended forums.

However, it was pointed out that there may be difficulties accessing some of the small self-help consumer groups in both sectors.

Guardianship issues

There were issues identified regarding resolution of problems for people with dementia and related illnesses, mostly in aged care settings, but not exclusively. It was identified as difficult to ascertain which Act – the *Mental Health (Treatment and Care) Act 1994*, or *Guardianship and Management of Property Act*, should be used, and that this was of no benefit to the consumer.

It was expressed that the *Guardianship and Management of Property Act* works very well, although concern was expressed that there is a gap for some individuals; and that there were inextricably linked factors regarding a lack of coercive powers with this Act. This causes discomfort for the Chief Psychiatrist by raising ethic issues for treating people under the *Mental Health (Treatment and Care) Act 1994* who do not have mental illness - for example, those needing a leg amputation.

An example depicting the clash of the *Mental Health (Treatment and Care) Act 1994* and the *Guardianship and Management of Property Act* was cited. It was a matter raised by two lawyers regarding a person under guardianship, who was in hospital and was unable to give consent to proposed treatment. However, when a medical team tried to treat the person, they became violent. Guardianship law does not give the guardian power to consent to a treating team to treat. On this occasion, the Chief Psychiatrist was approached, as the *Mental Health (Treatment and Care) Act 1994* is only the Act with explicit coercive powers.

However, if disability can be attached to a refusal to receive treatment, then a community care order could be made to provide coercive powers for treatment, but these are not necessary for medical treatment.

Further to this, the absence of the coercive powers for dementia care was raised, particularly regarding restrictive environments. It is then duty of care that keeps the door of the facility closed, though there are no legal orders authorising the person be detained.

These types of issues regarding mental dysfunction identify a gap in the *Guardianship and Management of Property Act.*

In addition, it was pointed out that no Ministerial guidance had been given to review the Guardianship Act, but it was recommended that the Attorney General and the Minister for Health be informed about the problems that had been revealed through the course of the review.

It was expressed by the disability representatives that a disability act with power for involuntary care and support was not advocated for as that sector did not want segregation.

Criteria for the making of mental health orders

The discussion focussed on capacity and risks of harm criteria for the making of mental health orders:

It was noted that a measure of capacity would be needed if the options including this were adopted; the capacity question would commence with the question - 'Does the person have the ability to understand and consent to treatment proposed in their circumstances?'

The option of retaining risk of harm criteria in addition to capacity criteria was raised and supported.

7. Forward Process – Ross O'Donoughue

It was proposed that a paper be drafted over the next few weeks to outline the outcomes of RAC discussions, picking up on advanced care directives and the model proposed by ADACAS. The paper will recommend that Government seek a middle-ground approach to legislative changes so that Cabinet can commit to and fix some of the immediate problems.

An integrated approach would be flagged, seeking the agreement of the Assembly for the first series of changes to the act, and to suggest a review in a few years time to investigate whether the updated legislation was serving the ACT well. A Recommendations Paper would be drafted outlining this approach. Several RAC members volunteered to participate in drafting of the Recommendations Paper - Cathy Fox, Claire Carpenter and Trish Mackey.

It was stated that once the issues regarding the Framework Paper were resolved, that the forensic matters would flow on.

RAC will reconvened in about one month. RAC members were advised that copies of the previous minutes – December 2008, are available on request.

Meeting Closed 12.20pm

FRAMEWORK OF MENTAL HEALTH AND RELATED LEGISLATION IN THE ACT.

Stage 3 Consultation Report to the RAC

NOTES TO RAC PRESENTATION

All page references below relate to Consultation Report

Definition of Mental Capacity

'Stakeholders were generally supportive of the concept of development of a standardised definition of mental capacity whilst cautious about aspects of the sample definition proposed, and looking for more information and detail about how the definition would be used. In the absence of a decided Framework, it was clearly difficult for stakeholders to imagine the effect of a capacity test in view of the range of legislative criteria, processes, principles and purposes that might potentially apply alongside it...'

'There was an overall sentiment that the concept needed more detail and explanation before stakeholders would feel confident about the particular form of definition proposed...' (Pg 3)

Placement of Mental Dysfunction Provisions

'... three submissions expressly supported retention of the mental dysfunction provisions in mental health legislation. No submission supported their complete removal. Seven submissions expressly supported 'fusion' legislation (the combination of a mental health and mental capacity or guardianship provisions in the one law. One stakeholder suggested a new alternative being retention of such of the mental dysfunction provisions as would be appropriate in an Act pertaining only to those who would receive clinical benefit from 'mental health treatment' (which would include those with mental dysfunction conditions who benefit from 'psychiatric' medication and other therapies). Another stakeholder did not express a clear preference for 'fusion' legislation overall but did suggest that the specific issue of placement of mental dysfunction conditions might be best addressed by 'fusion' legislation...' (Pg 8.)

Coercive powers in guardianship

'On balance, the majority of responding stakeholders supported the creation of coercive provisions in guardianship on the condition of a high level of formal oversight. These stakeholders included consumers, carers and clinicians.'

For

'....There was, rather, a simple acknowledgement that coercion was needed in specific situations from time to time, and exercised in any case without regulation other than the rather indistinct common law that currently applies.' (Pg10)

2.

Against

'...the addition of coercive powers under guardianship would broaden the range of contexts in which persons with impaired mental capacity could be subject to directed action against their preference. There is some concern about the impact of this, particularly in relation to disability consumers.

'...duty of care powers for service providers are currently sufficient to provide a legal basis for coercive action...'

'...the community does not want guardians, only attorneys appointed by the consumer, to have coercive powers.' (Pg 11)

Restrictive Practices

'Stakeholders appeared to be more comfortable approaching the coercive power issue in the context of restrictive practices...'

'Seven responses supported additional regulation of restrictive practices. Two maintained that current protections were sufficient....'

'The common law is not sufficient – 'the use of such practices requires requires the need for guidelines which are linked to legislation to provide standards, protocols and practices.' Pg 14

Contrary view: common law is sufficient.

Option A: Retain current arrangement

'Two respondents expressed explicit preference for Framework Option A with three other respondents implying their support for the Option.' (pg 16)

Option A + capacity criterion

Three approaches suggested:

- 'Give greater prominence to a mental capacity criterion within the existing 'risk of harm' and diagnosis-based framework.
- 'Replacement of the harm-based criteria with capacity criteria .....as a 'first step in on-going reform.''
- 'Replacement of the harm-based criteria with three 'preconditions' ...namely: [no capacity even with support; clinical benefit from mh treatment; and best interests]' (Pg 18)

3.

Option B: Alternative placement of 'mental dysfunction' provisions

'Option B was the least supported of the options proposed. Those who favour retention of the current form of the Act appeared to unanimously support its continued application to people with both mental dysfunction and mental illness conditions. Stakeholders favouring departure from the current scheme tended to favour Option C (under which the distinction between types of consumers would disappear).' (Pg 19.)

Option C: A mental capacity law

'Seven stakeholders making written submissions expressly supported Option C. In an eighth submission, a clear preference was not stated but it was put that Option C appeared to solve difficulties identified as relevant to the stakeholder.'

'Another stakeholder supported much of the conceptualisation of Option C but had concerns about its application across the board, preferring, in the first instance at least, a capacity-based mental health law.' (Pg 20.)

Attachment A
Forensic Mental Health Options Paper, consultation summary: March 2010

Written submission specifically addressing the Forensic Options Paper were received from:

- Human Rights Commission
- Mental Health Community Coalition ACT
- Public Advocate of the ACT
- Victims of Crime Coordinator
- Office of Children Youth and Family Support

	Special Hearings Options 1,2 and 3
Human Rights Commission	Supports victim being made aware of DPP decision not to prosecute. DPP should not be required to consult victim before making decision
Mental Health Community Coalition ACT	Special hearings do not adequately provide for the needs of mental health consumers. Recommend the establishment of a Mental Health Court in the ACT. Supports revisiting the way the court arrives at a 'limiting term'.
Public Advocate of the ACT	Support retaining special hearing provisions. Support review of 'limiting term'. To be determined at the time of referral to ACAT, not after the elapse of time.

	Criminal Responsibility and mental impairment Options 4-6
Mental Health Community Coalition ACT	Supports these options.
Public Advocate of the ACT	Supports these options.

	Information Sharing Options 7,8 and 9
Human Rights Commission	Supports the sharing of information within limitations to adherence with human rights and privacy principles
Mental Health Community Coalition ACT	Concerned about information sharing options – excessively broad, infringement on privacy rights. Recommend: • Provision for consumers to identify a carer who is able to receive information reasonably necessary to enable carer to undertake their role. • Regulation that allows sharing of information between agencies without unduly infringing on consumer's right to privacy.

Public Advocate of the ACT	Support ACAT sharing information with primary carer. Support information sharing between government service providers providing support to the consumer. Support information sharing by government service providers providing support to the consumer with non-government service providers and carers.

	Victims' Rights – Options 10-17
Human Rights Commission	Questions whether this is necessary for the Victims Impact Statements are necessary.
Victims of Crime Coordinator	Supports all options: • Victims should be able to provide 'victim submissions' in a court or ACAT hearing. • There should be a requirement for victims to be provided with information about their rights. • Agency that maintain a 'victims register' to be responsible for informing victims of rights, alert victims of relevant hearing dates, inform about escape, release and conditions of release. • VOCC should have a right of appearance to ensure victims are truly represented • VOCC right of appearance would require consideration of how VOCC would be able to use information to protect the right to privacy for the subject of the ACAT hearing.
Mental Health Community Coalition ACT	Support for victims but not for a role for victims in reviews conducted by ACAT. Supports opportunity to provide a Victim Impact Statement (option 10) but does not support an ongoing role in the treatment, placement or discharge of the person. Support options 12 (submission of appropriate victim impact report), 13 (ACAT required to advise how victims views considered). Does not support options 14, 15, 16, 17: • Involvement of victims after initial hearing or provision of victim submissions in ongoing reviews or hearing • The establishment of a victims register; • The provision of information about release, leave. May be appropriate to inform victim about consumer absconding from a facility. Recommend: • Role of victims limited to provision of victim impact statement. • Public campaign to educate the community emphasising the low risk of violent offending from mental health patients
Public Advocate of the	Supports options: 10, 12, 13, and 15.

ACT	Does not support options: 11, 14, 16, and 17. Support rights for victims of crime but within very define limits. Does not support options provision of condition of release, the establishment of a victims register; the provision of information about release, leave. Supports the provision of victim impact statements following a finding of non-acquittal and where person is found unfit to plead (options 10). Strongly opposed to a right of appearance for the Victims of Crime Coordinator. Recommends instead that the VOCC should seek leave to appear and the ACAT should be required to consider submissions from the forensic patient in relation to the request from the VOCC. Does not support victim being advised of release, leave or absconding, although does support the VOCC being informed about these matters where the ACAT has specific concerns.

	Decision Making – Options 18-25
Human Rights Commission	Reserves comments following the determination of the Framework Options Paper process. Supports reform of the way that 'limiting term' is established by the court. Advises against allowing for de facto preventative detention through forensic orders. Does not support a right of appearance for Attorney General (option 25).
Mental Health Community Coalition ACT	Recommend consideration of the Queensland model of decision making. • Mental Health Court provides determinations (on questions of fitness to plead and mental impairment); • Mental Health Review Tribunal conducts regular reviews.
Public Advocate of the ACT	Supports decision making about fitness to plead to remain with the court. Supports decision making about review of forensic orders to remain with the ACAT. Requests further information in relation to rationale for additional principles for decision makers (option 21) Supports ACAT to have the ability to make either a custodial or non-custodial forensic order. Supports the requirement that before ACAT or court orders detention a forensic patient, the decision maker obtain a certificate from the Chief Executive for the facility indicating that a placement is available and appropriate. Support right of appearance for the Attorney General.

	Corrections Management Act and the Question of Security– Options 26-31
Mental Health Community Coalition ACT	Services should strive for the healthiest environment possible and not compromise on the issue of equivalence of health care.
Public Advocate of the ACT	Supports options 26-31. Supports amendments to require that the Chief Executive for the AMC provide a forensic patient with access to facilties to contact the Public Advocate. Also, corrections staff to provide reasonable assistance for PA to have acces to forensic detainee.

	Children and young people– Option 32-33
Human Rights Commission	Restrictions on the right to privacy will need careful scrutiny.
Office of Children Youth and Family Support	Agree to the rentation of the existing scheme for the disposition and management of Children and Young People found mentally impaired or unfit to plead. Agree to the sharing of information by relevant agencies involved in the treatment and care of young detainees.
Mental Health Community Coalition ACT	Employ an approach of therapeutic jurisprudence. Agree to the sharing of information by relevant agencies involved in the treatment and care of young detainees.
Public Advocate of the ACT	Supports these options.

	Provisions relating to people with a disability– Option 34
Mental Health Community Coalition ACT	Employ an approach of therapeutic jurisprudence. Provide advocacy services when a person with a disability requires support to ensure processes are fair. .
Public Advocate of the ACT	Supports these options.

Forensic Mental Health Options Paper, consultation summary: March 2010

Written submission specifically addressing the Forensic Options Paper were received from:

- Human Rights Commission
- Mental Health Community Coalition ACT
- Public Advocate of the ACT
- Victims of Crime Coordinator
- Office of Children Youth and Family Support

	Special Hearings Options 1,2 and 3
Human Rights Commission	Supports victim being made aware of DPP decision not to prosecute. DPP should not be required to consult victim before making decision
Mental Health Community Coalition ACT	Special hearings do not adequately provide for the needs of mental health consumers. Recommend the establishment of a Mental Health Court in the ACT. Supports revisiting the way the court arrives at a 'limiting term'.
Public Advocate of the ACT	Support retaining special hearing provisions. Support review of 'limiting term'. To be determined at the time of referral to ACAT, not after the elapse of time.

	Criminal Responsibility and mental impairment Options 4-6
Mental Health Community Coalition ACT	Supports these options.
Public Advocate of the ACT	Supports these options.

	Information Sharing Options 7,8 and 9
Human Rights Commission	Supports the sharing of information within limitations to adherence with human rights and privacy

	principles
Mental Health Community Coalition ACT	Concerned about information sharing options – excessively broad, infringement on privacy rights. Recommend: • Provision for consumers to identify a carer who is able to receive information reasonably necessary to enable carer to undertake their role. • Regulation that allows sharing of information between agencies without unduly infringing on consumer's right to privacy.
Public Advocate of the ACT	Support ACAT sharing information with primary carer. Support information sharing between government service providers providing support to the consumer. Support information sharing by government service providers providing support to the consumer with non-government service providers and carers.

	Victims' Rights – Options 10-17
Human Rights Commission	Questions whether this is necessary for the Victims Impact Statements are necessary.
Victims of Crime Coordinator	Supports all options: • Victims should be able to provide 'victim submissions' in a court or ACAT hearing. • There should be a requirement for victims to be provided with information about their rights. • Agency that maintain a 'victims register' to be responsible for informing victims of rights, alert victims of relevant hearing dates, inform about escape, release and conditions of release. • VOCC should have a right of appearance to ensure victims are truly represented • VOCC right of appearance would require consideration of how VOCC would be able to use information to protect the right to privacy for the subject of the ACAT hearing.
Mental Health Community Coalition ACT	Support for victims but not for a role for victims in reviews conducted by ACAT. Supports opportunity to provide a Victim Impact Statement (option 10) but does not support an ongoing role in the treatment, placement or discharge of the person. Support options 12 (submission of appropriate victim impact report), 13 (ACAT required to advise how victims views considered).

	Does not support options 14, 15, 16, 17: • Involvement of victims after initial hearing or provision of victim submissions in ongoing reviews or hearing • The establishment of a victims register; • The provision of information about release, leave. May be appropriate to inform victim about consumer absconding from a facility. Recommend: • Role of victims limited to provision of victim impact statement. • Public campaign to educate the community emphasising the low risk of violent offending from mental health patients
Public Advocate of the ACT	Supports options: 10, 12, 13, and 15. Does not support options: 11, 14, 16, and 17. Support rights for victims of crime but within very define limits. Does not support options provision of condition of release, the establishment of a victims register; the provision of information about release, leave. Supports the provision of victim impact statements following a finding of non-acquittal and where person is found unfit to plead (options 10). Strongly opposed to a right of appearance for the Victims of Crime Coordinator. Recommends instead that the VOCC should seek leave to appear and the ACAT should be required to consider submissions from the forensic patient in relation to the request from the VOCC. Does not support victim being advised of release, leave or absconding, although does support the VOCC being informed about these matters where the ACAT has specific concerns.

	Decision Making – Options 18-25
Human Rights Commission	Reserves comments following the determination of the Framework Options Paper process. Supports reform of the way that 'limiting term' is established by the court. Advises against allowing for de facto preventative detention through forensic orders. Does not support a right of appearance for Attorney General (option 25).
Mental Health Community Coalition ACT	Recommend consideration of the Queensland model of decision making. • Mental Health Court provides determinations (on questions of fitness to plead and mental impairment); • Mental Health Review Tribunal conducts regular reviews.
Public Advocate of the ACT	Supports decision making about fitness to plead to remain with the court. Supports decision making about review of forensic orders to remain with the ACAT. Requests further information in relation to rationale for additional principles for decision makers (option 21) Supports ACAT to have the ability to make either a custodial or non-custodial forensic order. Supports the requirement that before ACAT or court orders detention a forensic patient, the decision maker obtain a certificate from the Chief Executive for the facility indicating that a placement is available and appropriate. Support right of appearance for the Attorney General.

	Corrections Management Act and the Question of Security– Options 26-31
Mental Health Community Coalition ACT	Services should strive for the healthiest environment possible and not compromise on the issue of equivalence of health care.
Public Advocate of the ACT	Supports options 26-31. Supports amendments to require that the Chief Executive for the AMC provide a forensic patient with access to facilties to contact the Public Advocate. Also, corrections staff to provide reasonable assistance for PA to have acces to forensic detainee.

	Children and young people– Option 32-33
Human Rights Commission	Restrictions on the right to privacy will need careful scrutiny.
Office of Children Youth and Family Support	Agree to the rentation of the existing scheme for the disposition and management of Children and Young People found mentally impaired or unfit to plead. Agree to the sharing of information by relevant agencies involved in the treatment and care of young detainees.
Mental Health Community Coalition ACT	Employ an approach of therapeutic jurisprudence. Agree to the sharing of information by relevant agencies involved in the treatment and care of young detainees.
Public Advocate of the ACT	Supports these options.

	Provisions relating to people with a disability– Option 34
Mental Health Community Coalition ACT	Employ an approach of therapeutic jurisprudence. Provide advocacy services when a person with a disability requires support to ensure processes are fair. .
Public Advocate of the ACT	Supports these options.

Mental Health (Treatment and Care) Act 1994 Review

Review Advisory Committee

Report on the Case Study Workshop 2 August 2010

Attendance:	
Ross O'Donoughue	Policy Division, ACT Health (Chair)
Linda Crebbin	General President – ACT Civil and Administrative Tribunal
Victor Martin	Legislation and Policy Branch, Justice and Community Services (JACS)
Richard Bromhead	Mental Health Policy Unit, ACT Health
Trish Mackey	Office of the Public Advocate, JACS
Christina Thompson	Office of the Public Advocate, JACS
Denise Caldwell	Office of the Public Advocate, JACS
Margaret Ford	Victim Support, JACS
Cathy Fox	Mental Health ACT
David Lovegrove	ACT Mental Health Consumer Network
Matt Hingston	Health Services Commissioner, JACS
Hugh Jorgensen	ACT Law Court and Tribunals Administration, JACS
Renate Moore	Social Policy and Implementation, Chief Ministers Department
Bill Kerley	Carers ACT
Greg Booth	ACT Policing
Simon Viereck	Mental Health Community Coalition
Bruno Aloisi	Crisis Assessment and Treatment Team, Mental Health ACT
Robyn Holder	Victims of Crime Coordinator, JACS
Sue Watson	Intensive Treatment and Support Service, DHCS
Teresa Tuite	Intensive Treatment and Support Service, DHCS
Velda Hunter	Mental Health Policy Unit, ACT Health (Secretiariat)

Apologies:	
Katrina Bracher	Community Health, ACT Health
Maree Mannion	DHCS
Chris Waller	Mental Health ACT
David James	Social Policy and Implementation, Chief Ministers Department
Sue Thomas	Carers ACT

1. Introduction

The purpose of the meeting was to discuss virtual case studies.

Following on from the last meeting of the RAC, case studies were developed to better understand the Framework questions, and to provide a starting point for discussions regarding application of suggested changes to the *Mental Health (Treatment and Care) Act 1994* (the Act). The purpose of the discussions was to help tease out the complexities of both risk of harm and capacity criteria for the making of mental health orders.

RAC members were requested not take notes of the cases, nor to talk about the case scenarios or discussions beyond the meeting, as individuals might associate a case or elements with their particular circumstances.

A Power Point presentation was shown that outlined the case studies, and two papers were tabled with extracts from the Act. Extracts were Schedule 28 and 36, criteria for the making of orders, and a definition of mental illness.

2. Case Studies

Four separate case studies were presented. These were composed through the cooperative efforts of the ACAT, the Public Advocate, and from clinical memory. They are amalgamations of scenarios occurring over the last 15 years, drawing on common threads from various cases to provide illustration for the discussions.

Each case study generated significant thought and discussion. The main points in summary were:

- The current requirement to apply only harm-based criteria creates unnecessary work for the police necessitating the application of Emergency Apprehension (EA) for people who are unwell but are not a threat. This causes excessive trauma and distress for individuals with mental illness, and also for police who are called to keep the peace.
- There are issues with an individual's capacity to give informed consent verses compliance.
- All of the current risks of harm criterion are equal – there is no hierarchy.
- However, should both capacity and risk of harm be considered for the making of orders, there arose some questions regarding which should be weighed up first.
- There is a need for formalising capacity-based criteria; this is currently a consideration for clinicians and the ACAT, but needs to be enshrined in law.

- There was advocacy for the inclusion of capacity-based criteria for the making of mental health orders, and for retaining risk of harm as criteria.
- For capacity-based criteria to be introduced for mental health orders, a time period, in addition to the 3 plus 7 day current period will be required to allow for detailed capacity assessment, but to also allow for the commencement of initial treatment

3. Outcomes

Mental Health Policy Unit will update the Recommendations Paper, for consideration of the RAC in the next few weeks. Individuals who previously volunteered to assist with this process will be included in the redrafting process.

Case Studies

Review Advisory Committee

2 August 2010

S28 Criteria for making psychiatric treatment order

The ACAT may make a psychiatric treatment order in relation to a person if—

(a) the person has a mental illness; and

(b) the ACAT has reasonable grounds for believing 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) the ACAT is satisfied that psychiatric treatment is likely to reduce the harm or deterioration (or the likelihood of harm or deterioration) mentioned in paragraph (b) 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.

S36 Criteria for making community care order

The ACAT may make a community care order in relation to a person if—

(a) the person is mentally dysfunctional; and

(b) the ACAT has reasonable grounds for believing 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) the ACAT is satisfied that treatment, care or support is likely to reduce the harm, or the likelihood of harm, mentioned in paragraph (b); and

(d) the ACAT is satisfied 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.

What do we want?

Criteria for making psychiatric treatment order

The ACAT may make a psychiatric treatment order in relation to a person if—

(a) the person has a mental illness; and

(b) ???

- CAPACITY (broadly speaking) includes the ability to:
    - Understand the facts involved
    - Understand the main choices
    - Weigh up the consequences of the choices
    - Understand how the consequences affect them
    - Communicate their decisions
- Capacity is:
    - Presumed until demonstrated otherwise
    - Decision specific
    - Assessed on decision-making ability not on the decision made
    - Assessed within cultural, language, ethnic and religious contexts.

(NSW Attorney General's Dept Capacity Toolkit 2008)

Harm criteria in Mental Health Act

- **Harm criteria EA (S37)** -
    - Police: has attempted is likely to attempt to (a) commit suicide, or (b) inflict serious harm to self or others.
    - MHO / Doctors: detention is necessary for person's own health or safety, social or financial wellbeing, or for protection of members of the public.

- **Harm Criteria for PTO / CCO (S28 &S36)**
    - (b)(i) do serious harm to self or another, or (ii) suffer serious mental or physical deterioration; and (c) treatment (care or support) is likely to reduce the harm or deterioration or likelihood of harm or deterioration.

- Health or safety are broad terms that are to be understood in terms of everyday usage. They can include any of the following:
    - harm to reputation or relationships
    - financial harm
    - self-neglect
    - neglect of others, e.g. the person's children: social, emotional, psychological, physical.
    - physical harm.

(NSW MHO Handbook)

Mental Health (Treatment and Care) Act 1994 Review
Review Advisory Committee

Date: Monday 21 June 2010

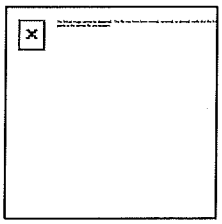
Time: 1.00 – 2.00 pm

Venue: Level 5 Conference Room 5
Community Health Building
1 Moore Street
Canberra City

Chair: Ross O'Donoughue

Agenda

1. **Attendance and Apologies**
2. **Previous Minutes**
3. **Business**
    a. Discuss the Mental Health 9Treatment and Care) Act 1994, Review Advisory Committee *Recommendations Paper June 2010.*



Mental Health (Treatment and Care) Act 1994 Review

Review Advisory Committee Meeting

Date: 21 June 2010

Time: 1.00 – 2.00 pm

Venue: Conference room 5 Level 5
11 Moore Street
Canberra

Meeting Report

Attendance:	
Ross O'Donoughue	Policy Division, ACT Health (Chair)
Victor Martin	Legislation and Policy Branch, Justice and Community Services (JACS)
Linda Crebbin	General President – ACT Civil and Administrative Tribunal
Richard Bromhead	Mental Health Policy Unit, ACT Health
Sean Costello	Human Rights & Discrimination Law Policy Adviser, JACS
Denise Caldwell	Office of the Public Advocate, JACS
David Lovegrove	ACT Mental Health Consumer Network
Margaret Ford	Victim Support, JACS
Cathy Fox	Mental Health ACT
Matt Hingston	Health Services Commissioner, JACS
Hugh Jorgensen	ACT Law Court and Tribunals Administration, JACS
Renate Moore	Social Policy and Implementation, Chief Ministers Department
Bill Kerley	Carers ACT
Chris Waller	Mental Health ACT
Simon Viereck	Mental Health Community Coalition
Kevin Kidd	Mental Health Capital Asset development Program
Denis Gellatly	ACT Policing

Dalane Drexler	ACT Mental Health Consumer Network
Sue Watson	Intensive Treatment and Support Service, DHCS
Velda Hunter	Mental Health Policy Unit, ACT Health (Secretariat)
Apologies:	
Katrina Bracher	Community Health, ACT Health
Brooke McKail	Mental Health Community Coalition
Mary Durkin	Human Rights Commission, JACS
Barry Folpp	ACT Corrective Services, JACS
Toni Hunt	ACT Corrective Services, JACS
David James	Social Policy and Implementation, Chief Ministers Department
Peter Marshall	Andrew Maconochie centre, JACS

1. Introduction

- The purpose of the meeting was to discuss the Mental Health (Treatment and Care) Act 1994, Review Advisory Committee (RAC) Recommendations Paper June 2010 (the Paper).
- The Paper was written following agreement at the last meeting of the RAC.
- The Paper focussed on capacity component of the act, comments

Issues Raised During the Discussion:

2. ACT Civil and Administrative Tribunal (ACAT)

- The recommendations in the Paper are not supported by the ACAT.
- Resources for ACAT would have to increase significantly to achieve the way forward described in the Paper.
- Consideration is needed for the current legal processes for applications, in particular for the timeframes for ACAT review of individuals.
- Poor outcomes were identified as the result of longer waits for the assessment process.
- Tension was also identified between quick assessments and ensure that the right assessor is employed.
- Whilst the system must have the ability to respond quickly, it also needs to be sufficiently flexible to ensure appropriate/longer timeframes to meet individual needs as needed.
- Tensions exist between time frames, rigour and resources.

3. The Evidence for Capacity-Based Legislation

- There is limited use of capacity-based legislation nationally or internationally, thus the knowledge-base regarding its application is as yet unable to provide information, for example on whether more, less or the same amount of people would be affected by the making of involuntary orders.

- Implementation of a capacity-based approach could raise issues of consent versus compliance. Applications for orders are not made when individuals are willing to have treatment even though they may lack capacity to give informed consent.

- It would be very difficult to use case studies, as there are very few applications that are not successful – relevant case studies would be of cases where orders have not been made, and are thus difficult to capture.

4. Mental Dysfunction

- Issues regarding mental dysfunction have been discussed numerous occasions during the review and consultation process and consensus has not been reached.

- One point of debate is the governance for managing individuals with mental dysfunction being included in mental health legislation. Argument for this is that the Act encompasses all mental health and serves all residents of the ACT, rather than a mental illness act that is not as inclusive.

- It is not agreed that Community Care Orders will be removed from mental health legislation regardless of advocacy by peak mental health community organisations.

- To resolve this issue, extensive consultation with the disability and aged sectors would be necessary.

- Government will be advised of this issue, and that consequentially, reviews of other related Acts are required to resolve problems and issues.

5. Process Timeframes

- Outcomes of the review and the Cabinet processes to finalise the legislation need to be completed and put through the Legislative Assembly before 2013.

6. Aspects yet to be dealt with

- The Paper does not address risk of harm as a threshold criteria, nor does it include Advanced Care Directives.

7. Meeting Outcome

- ACT Health will re-draft the Recommendations Paper

- The Policy Management Team (PMT) will be reconvened, and the RAC will meet more frequently, aiming at bi-monthly, but monthly initially

8. Meeting Closed: 2.00 pm

MH ACT - Review Advisory Committee Meeting - Meeting

File Edit View Insert Format Tools Actions Help

Save and Close | Send Update | Recurrence... | Invite Attendees

Appointment | Scheduling | Tracking

The following responses to this meeting have been received:

Name	Attendance	Response
Hunter, Velda	Meeting Organizer	None
Bromhead, Richard	Required Attendee	Accepted
O'Donoughue, Ross	Required Attendee	Accepted
ACTH-01M-CR5(L5-30s)	Required Attendee	Accepted
'AEQUITAS CONSULTANT' <em	Required Attendee	Accepted
Bracher, Katrina	Required Attendee	Declined
Bromhead, Richard	Required Attendee	None
'Brooke McKAil' <brooke.mcKail	Required Attendee	Declined
Byrne, Sarah	Required Attendee	None
Caldwell, Denise	Required Attendee	Accepted
Caruana, Jane	Required Attendee	None
'Claire Carpenter' <clairec@car	Required Attendee	None
'Consumer rep coordinator ACT	Required Attendee	None
Costello, Sean	Required Attendee	Accepted
Crebbin, Linda	Required Attendee	Accepted
'David Lovegrove' <dlovegrove	Required Attendee	None
Doig, Alyn	Required Attendee	None
'Don Byrne' <don.byrne@anu.i	Required Attendee	None
Durkin, Mary	Required Attendee	Declined
'Emma Robertson' <director@y	Required Attendee	None
'eo@actmhcn.org.au'	Required Attendee	None
Folpp, Barry	Required Attendee	Declined
Ford, Margaret	Required Attendee	Accepted
Fox, Catherine	Required Attendee	Accepted
Hingston, Matt	Required Attendee	Accepted
Hunt, Toni	Required Attendee	Declined
James, David	Required Attendee	Declined
'Jenny Thompson' <j.a.thomps	Required Attendee	None
Jorgensen, Hugh	Required Attendee	Accepted
'Lesa Gale' <Lesa.gale@afp.go	Required Attendee	Accepted
Mackey, Patricia	Required Attendee	Tentative
'Maree Livermore' <mliv@liverm	Required Attendee	None
Martin, Victor	Required Attendee	Accepted
Mayo, Nicole	Required Attendee	Accepted
MHACT Executive	Required Attendee	Accepted
Moore, Renate	Required Attendee	Accepted
O'Donoughue, Ross	Required Attendee	None
'Paul Shakeshaft' <Paul.Shakes	Required Attendee	Accepted
'Rosemary Agnew' <r.agnew@	Required Attendee	None
Ryan, James	Required Attendee	None

MH ACT - Review Advisory Committee Meeting - Meeting

File Edit View Insert Format Tools Actions Help

Save and Close | Send Update | Recurrence... | Invite Attendees

Appointment | Scheduling | Tracking

The following responses to this meeting have been received:

Name	Attendance	Response
Crebbin, Linda	Required Attendee	Accepted
'David Lovegrove' <dlovegrove	Required Attendee	None
Doig, Alyn	Required Attendee	None
'Don Byrne' <don.byrne@anu.a	Required Attendee	None
Durkin, Mary	Required Attendee	Declined
'Emma Robertson' <director@y	Required Attendee	None
'eo@actmhcn.org.au'	Required Attendee	None
Folpp, Barry	Required Attendee	Declined
Ford, Margaret	Required Attendee	Accepted
Fox, Catherine	Required Attendee	Accepted
Hingston, Matt	Required Attendee	Accepted
Hunt, Toni	Required Attendee	Declined
James, David	Required Attendee	Declined
'Jenny Thompson' <j.a.thomps	Required Attendee	None
Jorgensen, Hugh	Required Attendee	Accepted
'Lesa Gale' <Lesa.gale@afp.go	Required Attendee	Accepted
Mackey, Patricia	Required Attendee	Tentative
'Maree Livermore' <mliv@liverm	Required Attendee	None
Martin, Victor	Required Attendee	Accepted
Mayo, Nicole	Required Attendee	Accepted
MHACT Executive	Required Attendee	Accepted
Moore, Renate	Required Attendee	Accepted
O'Donoughue, Ross	Required Attendee	None
'Paul Shakeshaft' <Paul.Shakes	Required Attendee	Accepted
'Rosemary Agnew' <r.agnew@	Required Attendee	None
Ryan, James	Required Attendee	None
Scandrett, Kate	Required Attendee	None
'Simon Viereck' <simon.viereck	Required Attendee	Accepted
Snell, David	Required Attendee	Accepted
'Sue Connor' <scassoc1@netsp	Required Attendee	None
Trickett, Elizabeth	Required Attendee	None
Waller, Christine	Required Attendee	Accepted
Watchirs, Helen	Required Attendee	Accepted
Watson, Sue	Required Attendee	Accepted
Whale, Andrew	Required Attendee	Tentative
'William Kerley' <william.kerley1	Required Attendee	Accepted
PSQU Director	Optional Attendee	Accepted
Marshall, Peter	Optional Attendee	Declined
Click here to add a name		

Mental Health (Treatment and Care) Act 1994 Review
Review Advisory Committee

Date: Friday 10 December 2010

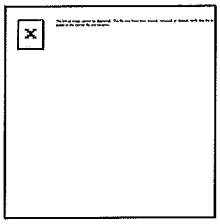
Time: 9.00 – 10.30 pm

Venue: Training Room 1, Level 1
Community Health Building
1 Moore Street
Canberra City

Chair: Ross O'Donoughue

Agenda

Discuss the Working Draft of the Paper for the Review of the *Mental Health (Treatment and Care) Act 1994*, that is included at included at Attachment A, In Confidence, for your information only.



Mental Health (Treatment and Care) Act 1994 Review
Review Advisory Committee

10 December 2010

Training Room 1
1 Moore Street
Canberra

Meeting Notes

Chair: Ross O'Donoughue

Apologies: Peter Marshall, Anthony Malone, Robyn Holder, Maree Mannion, Mark Collis, Katrina Bracher, Toni Hunt, Hugh Jorgensen, Nicole Mayo, Renate Moore, Mary Durkin.

Attendees

Ross O'Donoughue	Policy Division, ACT Health (Chair)
Cathy Fox	Mental Health Consumer Consultants
Richard Bromhead	Mental Health Policy Unit, ACT Health
Bill Kerley	Carers ACT
Simon Viereck	Mental Health Community Coalition ACT
Anita Phillips	Public Advocate
Sue Watson	Disability ACT
Denise Caldwell	Public Advocates Office
Trish Mackey	Public Advocates Office
David Lovegrove	ACT Mental Health Consumer Network
Linda Crebbin	General President – ACT Civil and Administrative Tribunal
Brooke McKail	Mental Health Community Coalition ACT
Victor Martin	Legislation and Policy Branch, Justice and Community Services (JACS)
Matt Hingston	Human Rights Commission, JACS
Sean Costello	Human Rights Commission, JACS

Herb Krueger	Mental Health ACT
Velda Hunter	Mental Health Policy Unit, ACT Health (Secretariat)

Welcome

Ross O'Donoughue welcomed the Review Advisory Committee (RAC).

Purpose

The purpose of the meeting is to discuss the current draft of the Working Draft of the Options Paper for the Review of the *Mental Health (Treatment and Care) Act 1994.* Points of view and points of clarification were invited. The planned process of this part of the review was explained – points of view will be heard today and input will be integrated into another iteration of the Working Draft. Following this, the RAC will be reconvened early in 2011 in order to distil and finalise advice for a brief to Cabinet.

Representatives of the Human Rights Commission expressed thanks to MHPU for the Working Paper, and expressed that it provided a fair balance of arguments, and was presented well.

Ongoing work on the Review

The RAC was advised that two rounds to recruit a dedicated officer for the review have been unsuccessful, and that now Mental Health Policy Unit (MHPU) will now recruit at a higher level. The position will be advertised before the end of 2010, with recruitment anticipated by mid January. MHPU is also recruiting a dedicated officer for administration support.

Attorney General and the Minister for Health Feedback

Richard Bromhead informed the RAC that the Attorney General and the Minister for Health are open to receive advice in the form of a Cabinet paper. They did not indicate if they have preferences for a particular approach; rather, that they are open to advice, with both wanting an open and transparent process.

Clearly stated positions

Victim Support ACT is in favour of a separate forensic statute, but has no position on the definitions of mental illness and mental disorder.

Human Rights Commissioners (HRC) have expressed a preference for Option A, supporting clearer definitions of mental illness and mental dysfunction. The commissioners are essentially against the creation of multiple Acts, and are not convinced of the benefits of having treatment and care supports placed into other legislation, or of the harm or negatives to people with mental illness by having people with mental dysfunction within the MHA. The commissioners support clarifying the use of capacity.

Public Advocate supports the Human Rights Commission's discussion.

Disability ACT doesn't want a separate Act, but rather supports inclusion; therefore Option B2b is not an option. Recommends one Act supporting all, including forensic provisions.

Carers ACT wants capacity included.

Discussion

It was expressed that the number of Acts that the RAC will recommend needs to be determined and will be part of recommendations to Cabinet.

Forensic provisions

Clarification on the progress of the forensic legislation was provided.

Whilst it was acknowledged that there are significant difficulties with the inclusion of everything in one piece of legislation, there is agreement for:

- Keeping forensic provisions within the MHA, rather than drawing in aspects of the Criminal Act; and that
- Diversion from criminal justice position should come early and people should not come anywhere near the criminal justice system.

Definitions of mental illness and mental dysfunction

The representative from the ACT Mental Health Community Coalition (MHCC) expressed positive support for the proposed definitions of mental illness and mental dysfunction as they are in line with those of other jurisdictions. Specific support was expressed for options supporting:

- Removal of mental dysfunction from the Mental Health Act (MHA); and
- Development of another Act.

Capacity

Issues regarding the approaches to introducing capacity into the legislation were a strong focus of RAC discussions. Following on from the Case Studies Workshop held on 2 August 2011, Option C (a purely capacity-based approach as articulated in the *Framework Paper*) is no longer being considered. However, other discussion and feedback on such legislation has been prompted. Issues raised and concerns expressed included:

- Risk of harm needs to balanced with capacity;
- A strengthened, faster, staged approach with clear milestones for the introduction of capacity that allows for the experiences of jurisdictions such as Northern Ireland should be considered;
- Whilst the addition of a capacity-based approach has had broad agreement, concern was raised as to whether this would add burden to the timeframes for assessment;

- The mechanism for capacity-based processes as set out in the first draft of the Working Paper was a concern for the ACT Civil and Administrative Tribunal (ACAT), as more time for assessment would be needed. This creates a need for careful consideration of the impact of legislative changes on procedural issues;

- The staged approach to introduction that was articulated in the earlier draft of the Working Paper reflects some of the views expressed at the last meeting but this approach needs to be clearly articulated and strengthened. It requires, a future review, following a stated period of data gathering, research into international experiences and focus on the best means to articulate the capacity focus in the legislation;

- It was expressed that capacity would be a consideration for the making of Emergency Orders, as this should be a trigger for consideration of the need for deprivation of liberty for up to four hours. In this case, there is a judgement of capacity in that threshold, but this is different to the definition of capacity in the legislation.

There was discussion on the balance of potential benefits and harms to individuals through the introduction of a capacity-based approach, and also about the differences to the outcomes for people who are subject to the legislation. It was expressed that:

- In the absence of clear advocacy for any particular approach, how could we be assured that the system would be any better than it is now?

- Further to this, it was questioned whether this would be an approach with which consumers could be happy;

- Of concern is increasing the risk of subjecting people to forensic orders or to the criminal justice system;

- It was reported it is agreed across Australia that regardless of the framework of legislation, tribunals essentially deal with the people with similar issues who need support from legislation; that is, people who require involuntary intervention from the state.

- Capacity is already a factor that is considered when a tribunal looks at applications for orders;

- The relative benefits, harms, and personal costs to individuals brought about by the introduction of capacity into the current administration will be balanced by a systematically supported consideration of capacity;

- Following the Case Study Workshop in August, it can be anticipated that there may not be any marked changes to the number of people who would be subjected to the legislation (with the possible exception of older persons). However, such changes will enable increased understanding of capacity and its significance. Thus, being explicit about capacity in the legislation signals its' important to the community;

- As a result of the Review, carers now have a strong understanding and interest in capacity and what it involves. If a distinct capacity approach is not going to be taken, there is a need to provide this advice to the community. In addition, carers do not want the processes of the public service to overshadow outcomes or prevent capacity from being introduced into the framework;

- The concept of capacity requires clarification to reduce the uncertainly that is expressed by clinicians and health professionals regarding legal authority;

- The question of the appropriateness of recommendations for location of capacity within other Acts was raised. It was suggested that this was strictly within the purview of the *Guardianship and Management of Property Act* (GMP), and not the MHA. However, it was agreed that as RAC deliberations had included the consideration of locating capacity outside the MHA, then recommendations for consideration of capacity in any other Act was within RAC scope.

- The RAC's consideration of capacity is specifically for decisions within the mental health context, and in relation to the risk of harm criteria. It should also include the right of a person to make decisions about their own treatment. There is an area in the MHA where capacity is still specific and significant, and the entitlement to treatment should be available regardless of capacity;

- The RAC was advised that capacity is a topic of current discussion among Public Advocates and Tribunal members nationally and internationally.

Coercive Powers

Coercive power has been a recurrent discussion theme of the RAC. Lack of RAC consensus was expressed regarding points such as:

- Decisions regarding coercive powers not being the responsibility of a group such as this, and were concepts for another venue and discussion;

- The intent of the MHA should be to treat only people with mental illness and to prevent mental illness.

- Difficulties arise when actions enabled by the MHA are applied to permit treatment of disorders that are not related to psychiatry or to mental health, as is the case under the current MHA. The MHA is the only legislation that includes any powers to limit liberty, but there are occasions when people are subjected to the MHA in the absence of mental illness.

- Coercive powers should be dealt with separately from the MHA, but if these are to be made explicit and adopted, then subsequent

adaptations of the entire legislative framework is necessary. This may result in recommendations to review other Acts; and

- The scheme for involuntary orders should properly support substitute decision making.

Recovery

It was outlined that the benefits from the iterative processes aided will serve to frame the MHA in a more modern and recovery focused way, but the history of mental health legislation is to protect the rights of people at times of vulnerability, or for the prevention of harm to others, thus exercising a protective approach. However, the importance of recognising that there are tensions between the prevention of harm and dignity of individuals was noted. Consumers expressed that

- The MHA should enable and empower consumers, assisting people to develop their own agency to develop options and choices with human rights and dignity paramount;
- Should be based on recovery with a community focus;
- What the MHA does for people who don't need involuntary orders should have a focus on recovery; however
- There is a need to deal with the threshold issues and what the MHA might say in terms of involuntary treatment.

It is anticipated that an updated Working Draft of the Options Paper for the Review of the *Mental Health (Treatment and Care) Act 1994* will be circulated early in the New Year, and will clarify options for Government.

Public Advocate of the ACT

The vision of the Public Advocate of the ACT is for a caring community where the rights and interests of vulnerable people are protected

Mental Health Review Advisory Committee

Purpose of the Mental Health Act ACT.

While there is probably general consensus as to the purpose and objectives of the MHA, I think it would be worthwhile to discuss the views of the RAC about this. This would then be useful in developing guiding principles that would be stated up front at the beginning of the MHA. Other jurisdictions have such statements of principle which allow the Act to focus and be clear about its purpose.

Some examples of possible objectives for the MHA might be:

- To provide legislation for compulsory detention/treatment of people suffering a mental disorder who may be at risk of harm to themselves (and/or others).
- This Act details procedures, practices and rights in relation to people who are detained under psychiatric treatment orders.
- The Millan Committee Report which structured the revised Scottish legislation recommended four up front objectives of the Act – statement of Principles, procedures when invoking Compulsory Powers, how these affect the Forensic system and the Rights and Safeguards of people under orders.
- A statement as to whether the Act is primarily concerned with law and order issues (concepts of 'danger' and 'risks to self and others'), or aims to strike a balance between the general interests of society and the protection of individual Rights, (or are both possible?).
- A stated aim that the legislation focuses only on involuntary treatment, in a hospital or community setting (like the Queensland Act).
- The principles underlying the Dutch approach to mental illness that is based on the treatment of the person. (This may require political will, as detention for people suffering mental disorders is often regarded as a community safety issue over and above treatment).

Mail PO Box 1001 Civic Square ACT 2608 **Address** Level 3, 12 Moore Street Canberra City ACT 2601
Telephone 02 6207 0707 **Facsimile** 02 6207 0688 **Email** pa@act.gov.au **www.publicadvocate.act.gov.au**

Definitions

My main argument for having one definition of "**mental disorder**" is that to try to split people suffering complex conditions into one or other categories is not only well nigh impossible, it is also discriminatory and potentially degrading. From the discussions about this within RAC, I think there is some reluctant acceptance of the one definition, the sticking point being that if there is one definition, there can only be one Act, even with separate sections

I strongly support this approach, and the ACT (and some other jurisdictions in Australia) is out of step with contemporary mental health policy in clinging to the concept that people's disorders can be classified into neat diagnoses.

The revised England and Wales *Mental Health Act 1983* has the one definition of **Mental Disorder – any disorder or disability of the mind.** (It excludes "learning disability" and similar conditions that are defined under disability legislation, unless that disability is associated with abnormally aggressive or seriously irresponsible conduct.) The E&W Act accepts that the categories must be flexible in responding to unique individuals.

The new **Scottish *Mental Health (Treatment and Care) Act 2003***, uses the one definition of **Mental Disorder – mental illness, personality disorder, or learning disability, however caused or manifested.** This covers all bases regardless of aetiology, with the focus on providing treatment options rather than putting people into "boxes" and involving them, their "nominated person", carers and others in the treatment decisions.

Many European countries have made changes to their mental health legislation in recent years, largely in response to the UN and European Conventions. **The Netherlands** is a typical example. It has one definition of **Mental Disorder – having an impairment of mental faculties.** While this is very broad, the Act is very focused – the ***Psychiatric Hospitals (Compulsory Admissions) Act 1994*** – clearly identifying that the restrictive rules only apply when detention is the most appropriate action. The legislation does not include compulsory treatment, and all other aspects of mental health come under general health provisions.

How to address the need to treat the physical health of a mental health patient, if they are refusing consent.

This is a highly contentious issue, mainly because it doesn't appear that any legal system has the ideal answer. Accordingly we, in the ACT have the opportunity to be ground breaking in finding a solution.

It is important to analyse the different elements of the problem rather than coming up with knee-jerk "quick fixes" (including flick passing it to the Guardianship system!).

1. The first element is that of "informed consent".
2. Interwoven with this is the concept of "capacity".
3. Then there is the difference between mental health and physical health treatment.

1. Informed consent

Statute and common law has embedded the right of every individual for complete autonomy for what happens to their own body. No-one can treat a patient in any way, except in a life or death emergency, (and even then there are some restrictions), unless the person has given consent, and this must be *informed consent*, i.e. the person must understand the nature of the treatment, be made aware of any risks, be able to weigh the consequences and be able to communicate consent. A health practitioner who treats without first obtaining this can be charged with trespass, assault and/or negligence. This applies to treatment for mental health just as it does for physical health.

2. Capacity

A person who does not have the capacity to give *informed consent* for whatever reason, has the Right to have a substitute decision maker consulted and s/he can give consent on their behalf.

The Guardianship and Management of Property Act 1991 ACT (G&MPA) authorises the ACT Civil and Administrative Tribunal (ACAT) to be able to appoint a guardian where a person has a significantly *impaired decision making ability,* (i.e. does not have the capacity to make a decision or give informed consent), and decisions need to be made in relation to the person's health or welfare. The impairment of their decision making ability can be from a wide range of conditions, including a mental condition.

An application under the G&MPA requires that the person is assessed by a suitably qualified practitioner as having "incompetence" and must go before a Hearing of the ACAT. It is a serious, usually long term, and onerous course of action, not to be taken lightly. Although the current G&MPA contains the provision to temporarily appoint the Public Advocate under special circumstances of urgency, this authority is rarely used now that health practitioners can appoint Health Attorneys to give consent to medical treatment for people who lack capacity.

The above scenario is very different from the situation where a person (albeit with a mental disorder) is requiring physical treatment but refusing to accept it. None-the-less the "blunt instrument of incompetence" is often brought to bear in order to have someone able to give consent and authorise the treatment.

Some overseas jurisdictions use a more focused means by identifying that the person is in need of support in making a decision because they "*do not appear to be capable of understanding the purpose of the treatment that is likely to alleviate their condition*". This is far more likely to be the scenario, and accordingly there should be a more tailored solution to the problem than resort to the Guardianship system.

3. Treatment for mental versus physical health

Within the current MHA (ACT) there are several provisions to treat someone with a mental health condition without consent, even to use restraint if necessary. It is curious that the same do not apply to the treatment of physical conditions.

Is this because people with mental health conditions are assumed to be lacking capacity and therefore their *informed consent* is not sought? Is it because it is assumed that a person with a mental illness is at a risk to themselves or others and therefore must be subjected to detention and/or treatment for safety sake? Is it because it is assumed that people with mental health conditions will never voluntarily seek or consent to treatment?

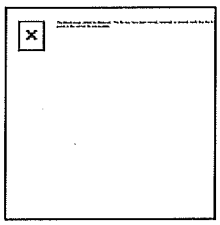
Whatever the reason, it seems that this disparity in treatments should be challenged. The Scottish MHA allows compulsory orders to authorise treatment for physical conditions that may be contributing to the mental health condition. Surely it is not a very long stretch to suggest that orders, especially those for people living in the community, should be able to include physical treatment when required, especially maintenance of treatment regimes for chronic illnesses such as diabetes and heart conditions.

My suggestions for possible solutions to this problem are:

- The MHA be amended to allow when **compulsory Orders** are made they **include the treatment of physical conditions** as well, as appropriate, and that the provisions of the Act, including the use of restraint would apply to the treatment of physical conditions if necessary, under the same guidelines and procedures as exist.
- An additional safeguard would be, as is practice already, that when a person is not capable of giving informed consent, a **duly appointed Health Attorney could consent to the treatment** recommended by the health professional. The legislation could be expanded to allow them to also consent to restraint or other actions required if necessary in order to perform the treatment. In any case, once the health professional has the substitute decision maker's consent to treatment, restraint could be used according to normal *duty of care* procedures.
- Finally a more empowering way to address this problem for people with mental health disorders, is to encourage them to complete **Advance Health Directives**, as is now possible in W.A., in consultation with a health practitioner, that can give consent to treatment even if the person becomes temporarily incapable of doing so.

Anita Phillips
ACT Public Advocate

Mail PO Box 1001 Civic Square ACT 2608 **Address** Level 3, 12 Moore Street Canberra City ACT 2601
Telephone 02 6207 0707 **Facsimile** 02 6207 0688 **Email** pa@act.gov.au **www.publicadvocate.act.gov.au/**



Mental Health (Treatment and Care) Act 1994 Review
Review Advisory Committee

4 February 2011

Training Room 1
1 Moore Street
Canberra

Meeting Notes

Chair: Ross O'Donoughue

Apologies: Sean Costello, Anita Phillips, David Snell, Robyn Holder, Barry Folp, Kate Starik, Denise Caldwell, Maree Mannion, Ryan James,

Attendees	
Ross O'Donoughue	Policy Division, ACT Health (Chair)
Richard Bromhead	Mental Health Policy Unit, ACT Health
Matt Hingston	Human Rights Commissioner, JACS
Renate Moore	Chief Ministers Department
Vera Van de Velde	Community Health
Dalane Drexler	ACT Mental Health Consumer Network
Sue Watson	Disability ACT
Victor Martin	Legislation and Policy Branch, Justice and Community Services (JACS)
Trish Mackey	Public Advocates Office
Brian McLeod	Public Advocates Office

Simon Viereck	Mental Health Community Coalition ACT
Linda Crebbin	General President – ACT Civil and Administrative Tribunal
Bill Kerley	Carers ACT
Greg Booth	ACT Policing
Tony Malone	ACTCS
Margaret Ford	Victim Support ACT
Simone Fowlie	ACTCS
Velda Hunter	Mental Health Policy Unit, ACT Health (Secretariat)

Ross O'Donoughue welcomed the Review Advisory Committee (RAC). The purpose of the meeting was to discuss the Working Draft of the Options Paper (the Paper) for the Review of the *Mental Health (Treatment and Care) Act* 1994 (the MHA).

Richard Bromhead provided the context for the meeting, anticipating that this would be the final RAC meeting before the drafting of the Cabinet Submission advising Government of options for the framework for the legislation.

Ross O'Donoughue invited attendees to discuss overarching views, and seek clarification if required on the various sections of the paper.

Overall responses to the paper were positive.

General comments included:

- That the MHA should include a section on managing children and young people as this presents challenges for the ACT Civil and Administrative Tribunal (ACAT) and Mental Health ACT as there was no clear legislative guidance;

- That it could be of value to include definitions of treatment in the MHA, and that it would be appropriate to revisit this issue. It was noted that the Western Australian MHA includes a definition of treatment.

The Options as Presented in the Paper[1]

The RAC was invited to comment, or put forward comments out of session regarding the Options as presented in the Paper. Suggestions were:

- The representative of the ACAT expressed that the Option A weakness – point 2 regarding the national agenda was not a weakness, as national consistency would mean that the various Acts could sit comfortably side by side.

- Representatives of the Public Advocate recommended omitting the recommendations to amend the Guardianship and Management of Property Act (GMP), citing that this recommendation was beyond the role of the RAC. However, this was contested, as it was felt that the recommendation was a genuine outcome of the Review's consultations and RAC considerations.

Evaluating the Options

Representatives of the ACT Mental Health Community Coalition offered to provide additional words for inclusion in Table 1 – Evaluating the Options[2].

- These are included in italics at Appendix 2.

---

[1] Appendix 1
[2] Appendix 2

Definitions - Mental Illness (MI) and Mental Dysfunction (MD)

The RAC agreed that including definitions of MI and MD in the MHA was a priority, rather than an Act that did not make distinctions between MI and MD.

- The Northern Territory definition[3] of MI was broadly accepted, and it was expressed that such a definition:
    - Was generally preferred;
    - Clarifies that MI is not a subset of MD;
    - Supports the retention of a single Act;
    - Allows consideration of the negative symptoms of schizophrenia;
    - Acknowledges consultation input from the Review regarding internationally accepted clinical standards, however it is acknowledged that the lack of precision regarding 'internationally accepted clinical standards' can create difficulties for clinicians;
    - Requires contextualisation to include a range of presentations of diminished capacity such as the delirium caused by underlying illness;
    - Is helpful to clarify issues in a 'Mental Health Act' rather than a 'Mental Illness Act'; and
    - Provides the basis for clarification that the outcomes flowing on from decisions that an individual has an MI or a MD are distinctly different, and assists with accommodating these different courses of action.

Forensic Mental Health

Discussion regarding Forensic MH provisions was brief. It was expressed that:

- There was no more to add at this time, and that drafting would clarify the finer details; and
- The RAC would have a role to consider forensic provisions following Cabinet decisions.

Capacity

Further to the previous RAC discussions on capacity-based legislation, RAC members expressed that whilst capacity had posed a vexed issue, there had been significant value in its consideration, and that it would be a pity to walk away from these important discussions. Therefore, RAC recommends:

- That there be a review clause included in the amended MHA to ensure the reappraisal of capacity based legislation within a stated timeframe;

[3] Appendix 3

Recovery

Meeting participants gave positive responses to the Recovery section in the Paper, with consumer representatives agreeing. The RAC therefore agreed that:

- Recovery principles should be embedded in the Objectives of the amended MHA.

Harm

It was agreed that risk of harm should be retained in the MHA, and that is should be qualified as:

- Risk of harm to self and others;
- Risk of serious mental deterioration; and
- Risk of deterioration in order to support opportunities for early intervention.

Coercive Powers and Guardianship

Representatives of the Public Advocate expressed concerns about the recommendation to review the GMP. An understanding that the consequences for vulnerable people[4] were governed by Commonwealth law was clarified – Commonwealth law governs the residential facilities and not issues of restraint of residents. Whilst the RAC did not wish to exclude the recommendation to review the GMP, it was proposed to make less forthright the language in the recommendation.

[4] Appendix 3

Appendices

Appendix 1

"Options

In order to present RAC with a range of alternatives arising from previous RAC considerations and feedback four options are presented based on those laid out in the Framework Options Paper. For each of these the re-definition of "*mental illness*" and "*mental dysfunction*" is recommended. The additional elements of including "*capacity*" as a criterion and guidance on the interpretation of "*harm*" as a criterion are also recommended for each option.

The options are:

Option A Variation

Amend the existing MHA, redefining mental illness and mental dysfunction as separate entities. Include distinct sections:

a. A section for the provisions for involuntary treatment and care for mental illness; and

b. A section for involuntary treatment and care for mental dysfunction,

Option B2 Variation

Amend the existing MHA, remove mental dysfunction and community care orders, and establish either:

a. A new act to provide for the requirements of community care orders (the *Community Care Act*); or

b. Make provisions for the requirements of community care orders within other legislation. (eg. an ACT Disability Act modelled on Victoria's *Disability Act 2006*).

Option B3 Variation

Amend the existing MHA as mental illness specific; and

a. The existing *Guardianship and Management of Property Act* (GMPA) to include:

    i. A focused definition of mental dysfunction (excluding mental Illness);

    ii. Coercive powers to cover community care orders; and

    iii. Clarification of involuntary care.

Option B4 Variation

Amend the existing MHA as mental illness specific; and

a. The existing *Guardianship and Management of Property Act* (GMPA) to include broadly stated coercive power, which would give a guardian a general power to authorise the restriction of liberty or coercive practises implicit in their current decision-making."

Mental Health (Treatment and Care) Act 1994 Review Advisory Committee Options Paper January 2011, Page 5

Appendix 2

Evaluating the Options

Table 1 proposes some of the strengths and weaknesses of each of the options described above – updates from this RAC meeting included in *italics*.

	Strengths	Weaknesses
Option A Variation	Provides for legislation that supports, in a consistent manner people with a variety of mental health issues, be they caused by mental illness or mental dysfunction. Takes into account the concerns raised by the Human Rights Commission and the Public Advocate that the ACT Mental Health Act should be relevant to all Canberrans.	Is inconsistent with Mental Health Acts across Australia that deal mostly with mental illness exclusively. Is therefore inconsistent with the Fourth National Mental Health Plan (approved by the Australian Health Minister's Council) requiring implementation of nationally consistent legislation. Is inconsistent with concerns raised by consumers and the community mental health sector that stigmatisation of people with mental illness and mental dysfunction occurs by association with each other. *Is inconsistent with concerns raised by mental health consumers and the community mental health sector about stigmatisation and inconsistency with accepted medical standards. They suggest sections relating to mental dysfunction would be more appropriately located in disability legislation.*
Option B2 Variation	Takes into account the concerns raised by consumers and the community mental health sector. *Takes into account the concerns regarding stigma and location of medical dysfunction raised by consumers and the community mental health sector.*	
Option B3 Variation	Takes into account the concerns raised by consumers and the community mental health sector. *Takes into account the concerns regarding stigma and location of medical dysfunction raised by consumers and the community mental health sector.*	
Option B4 Variation	Takes into account the concerns raised by consumers and the community mental health sector. *Takes into account the concerns regarding stigma and location of medical dysfunction raised by consumers and the community mental health sector.*	

Table 1.

Appendix 3

A model for a new definition of mental illness in the MHA is the legislation in the Northern Territory of Australia (NT) that presents a definition of mental illness that is in keeping with nationally and internationally accepted clinical standards. An extract of the NT definition reads:

"(1) In this Act, ***mental illness*** means a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person in one or more of the areas of thought, mood, volition, perception, orientation or memory and is characterised:

(a) by the presence of at least one of the following symptoms:

(i) delusions;

(ii) hallucinations;

(iii) serious disorders of the stream of thought;

(iv) serious disorders of thought form;

(v) serious disturbances of mood; or

(b) by sustained or repeated irrational behaviour that may be taken to indicate the presence of at least one of the symptoms referred to in paragraph (a).

(2) A determination that a person has a mental illness is only to be made in accordance with internationally accepted clinical standards".

Mental Health (Treatment and Care) Act 1994 Review Advisory Committee Options Paper January 2011, Page 10

Appendix 4

"The consequences for other vulnerable populations already catered for by the *Guardianship and Management of Property Act* (GMP Act), such as the elderly and people with intellectual disabilities, have not been adequately taken into account by the Review of the MHA. To address the issue adequately would require a review of the GMP Act, and is beyond the scope of the present Review. This area is part of the legislative responsibilities of the Attorney General."

Mental Health (Treatment and Care) Act 1994 Review Advisory Committee Options Paper January 2011, Page 14

Mental Health Review
Advisory Committee

Purpose of the Mental Health Act ACT.

While there is probably general consensus as to the purpose and objectives of the MHA, I think it would be worthwhile to discuss the views of the RAC about this. This would then be useful in developing guiding principles that would be stated up front at the beginning of the MHA. Other jurisdictions have such statements of principle which allow the Act to focus and be clear about its purpose.

Some examples of possible objectives for the MHA might be:

- To provide legislation for compulsory detention/treatment of people suffering a mental disorder who may be at risk of harm to themselves (and/or others).
- This Act details procedures, practices and rights in relation to people who are detained under psychiatric treatment orders.
- The Millan Committee Report which structured the revised Scottish legislation recommended four up front objectives of the Act – statement of Principles, procedures when invoking Compulsory Powers, how these affect the Forensic system and the Rights and Safeguards of people under orders.
- A statement as to whether the Act is primarily concerned with law and order issues (concepts of 'danger' and 'risks to self and others'), or aims to strike a balance between the general interests of society and the protection of individual Rights, (or are both possible?).
- A stated aim that the legislation focuses only on involuntary treatment, in a hospital or community setting (like the Queensland Act).
- The principles underlying the Dutch approach to mental illness that is based on the treatment of the person. (This may require political will, as detention for people suffering mental disorders is often regarded as a community safety issue over and above treatment).

Definitions

My main argument for having one definition of "**mental disorder**" is that to try to split people suffering complex conditions into one or other categories is not only well nigh impossible, it is also discriminatory and potentially degrading. From the discussions about this within RAC, I think there is some reluctant acceptance of the one definition, the sticking point being that if there is one definition, there can only be one Act, even with separate sections

I strongly support this approach, and the ACT (and some other jurisdictions in Australia) is out of step with contemporary mental health policy in clinging to the concept that people's disorders can be classified into neat diagnoses.

The revised England and Wales ***Mental Health Act 1983*** has the one definition of **Mental Disorder – any disorder or disability of the mind.** (It excludes "learning disability" and similar conditions that are defined under disability legislation, unless that disability is associated with abnormally aggressive or seriously irresponsible conduct.) The E&W Act accepts that the categories must be flexible in responding to unique individuals.

The new **Scottish** ***Mental Health (Treatment and Care) Act 2003***, uses the one definition of **Mental Disorder – mental illness, personality disorder, or learning disability, however caused or manifested.** This covers all bases regardless of aetiology, with the focus on providing treatment options rather than putting people into "boxes" and involving them, their "nominated person", carers and others in the treatment decisions.

Many European countries have made changes to their mental health legislation in recent years, largely in response to the UN and European Conventions. **The Netherlands** is a typical example. It has one definition of **Mental Disorder – having an impairment of mental faculties.** While this is very broad, the Act is very focused – the ***Psychiatric Hospitals (Compulsory Admissions) Act 1994*** – clearly identifying that the restrictive rules only apply when detention is the most appropriate action. The legislation does not include compulsory treatment, and all other aspects of mental health come under general health provisions.

How to address the need to treat the physical health of a mental health patient, if they are refusing consent.

This is a highly contentious issue, mainly because it doesn't appear that any legal system has the ideal answer. Accordingly we, in the ACT have the opportunity to be ground breaking in finding a solution.

It is important to analyse the different elements of the problem rather than coming up with knee-jerk "quick fixes" (including flick passing it to the Guardianship system!).

1. The first element is that of "informed consent".
2. Interwoven with this is the concept of "capacity".
3. Then there is the difference between mental health and physical health treatment.

1. Informed consent

Statute and common law has embedded the right of every individual for complete autonomy for what happens to their own body. No-one can treat a patient in any way, except in a life or death emergency, (and even then there are some restrictions), unless the person has given consent, and this must be *informed consent*, i.e. the person must understand the nature of the treatment, be made aware of any risks, be able to weigh the consequences and be able to communicate consent. A health practitioner who treats without first obtaining this can be charged with trespass, assault and/or negligence. This applies to treatment for mental health just as it does for physical health.

2. Capacity

A person who does not have the capacity to give *informed consent* for whatever reason, has the Right to have a substitute decision maker consulted and s/he can give consent on their behalf.

The Guardianship and Management of Property Act 1991 ACT (G&MPA) authorises the ACT Civil and Administrative Tribunal (ACAT) to be able to appoint a guardian where a person has a significantly *impaired decision making ability,* (i.e. does not have the capacity to make a decision or give informed consent), and decisions need to be made in relation to the person's health or welfare. The impairment of their decision making ability can be from a wide range of conditions, including a mental condition.

An application under the G&MPA requires that the person is assessed by a suitably qualified practitioner as having "incompetence" and must go before a Hearing of the ACAT. It is a serious, usually long term, and onerous course of action, not to be taken lightly. Although the current G&MPA contains the provision to temporarily appoint the Public Advocate under special circumstances of urgency, this authority is rarely used now that health practitioners can appoint Health Attorneys to give consent to medical treatment for people who lack capacity.

The above scenario is very different from the situation where a person (albeit with a mental disorder) is requiring physical treatment but refusing to accept it. None-the-less the "blunt instrument of incompetence" is often brought to bear in order to have someone able to give consent and authorise the treatment.

Some overseas jurisdictions use a more focused means by identifying that the person is in need of support in making a decision because they "*do not appear to be capable of understanding the purpose of the treatment that is likely to alleviate their condition*". This is far more likely to be the scenario, and accordingly there should be a more tailored solution to the problem than resort to the Guardianship system.

3. Treatment for mental versus physical health

Within the current MHA (ACT) there are several provisions to treat someone with a mental health condition without consent, even to use restraint if necessary. It is curious that the same do not apply to the treatment of physical conditions.

Is this because people with mental health conditions are assumed to be lacking capacity and therefore their *informed consent* is not sought? Is it because it is assumed that a person with a mental illness is at a risk to themselves or others and therefore must be subjected to detention and/or treatment for safety sake? Is it because it is assumed that people with mental health conditions will never voluntarily seek or consent to treatment?

Whatever the reason, it seems that this disparity in treatments should be challenged. The Scottish MHA allows compulsory orders to authorise treatment for physical conditions that may be contributing to the mental health condition. Surely it is not a very long stretch to suggest that orders, especially those for people living in the community, should be able to include physical treatment when required, especially maintenance of treatment regimes for chronic illnesses such as diabetes and heart conditions.

My suggestions for possible solutions to this problem are:

- The MHA be amended to allow when **compulsory Orders** are made they **include the treatment of physical conditions** as well, as appropriate, and that the provisions of the Act, including the use of restraint would apply to the treatment of physical conditions if necessary, under the same guidelines and procedures as exist.
- An additional safeguard would be, as is practice already, that when a person is not capable of giving informed consent, a **duly appointed Health Attorney could consent to the treatment** recommended by the health professional. The legislation could be expanded to allow them to also consent to restraint or other actions required if necessary in order to perform the treatment. In any case, once the health professional has the substitute decision maker's consent to treatment, restraint could be used according to normal *duty of care* procedures.
- Finally a more empowering way to address this problem for people with mental health disorders, is to encourage them to complete **Advance Health Directives**, as is now possible in W.A., in consultation with a health practitioner, that can give consent to treatment even if the person becomes temporarily incapable of doing so.

Anita Phillips
ACT Public Advocate

ACT Government Health

Review of the ACT Mental Health Act
Review Advisory Committee

ANNOTATED AGENDA

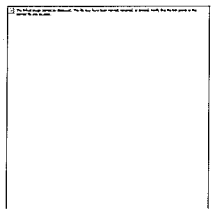
Monday 20 June 2011

Conference Room, 3rd Floor 11 Moore Street

12:30-2:00pm

No	Item	Responsibility
1	Welcome - Julia Bocking is the new MH JHAD MH Consumer Consultant representative on the RAC - Sara Wade-Vuletic is new Review Administration Officer	Richard Bromhead
2	Apologies Anita Phillips, Ross O'Donoughue, Trina Bracher, Emma Robertson, Anthony Malone, Margaret Ford, Catherine Fox, Sue Connor, Vera Van de Velde, Simone Fowlie. *Norm Fraser will attend in place of Kate Stick, Barry Folpp will attend for Bernadette Mitcherson.*	
3	Update on review Framework CabSub to Cabinet today 20th June	Steve Druitt
4	Set-up of working groups Six working groups currently being set up, need to check we have the best representation from RAC, other expertise is also being invited. Background papers for some groups sent with agenda. Others available at the meeting. (Technical Matters working group will work item by item through the list of changes suggested to it)	Steve Druitt

Lunch will be provided



Mental Health (Treatment and Care) Act 1994 Review
Review Advisory Committee

20 June 2011

Conference Room, Level 3
11 Moore Street
Canberra

Meeting Notes

Chair: Richard Bromhead

1. Welcome

2.Apologies Anita Phillips, Ross O'Donoughue, Trina Bracher, Pam Jenkins, David Snell, Emma Robertson, Anthony Malone, Margaret Ford, Catherine Fox, Sue Connor, Vera Van de Velde, Simone Fowlie, John Hinchey

Attendees	
Richard Bromhead	Mental Health Policy Unit, Health
Steve Druitt	Mental Health Policy Unit, Health
Wendy Kipling	Access and Acute Mental Health Services
Trish Mackey	Public Advocates
Matt Hingston	Human Rights Commissioner, JACS
Renate Moore	Chief Ministers Department
Sue Watson	Disability ACT
Victor Martin	Legislation and Policy Branch, Justice and Community Services (JACS)
Simon Viereck	Mental Health Community Coalition ACT
Linda Crebbin	General President – ACT Civil and Administrative Tribunal
Bill Kerley	Carers ACT
Sam Dellamarta	Human Rights Commission
Julia Bocking	Mental Health Consumer Consultant
Peter Marshall	ACT Corrective Services
Herb Krueger	Mental Health Rehabilitation and Specialty Services
Denise Caldwell	Public Advocate of the ACT
Brianna McGill	Human Rights Commission
Sara Wade-Vuletic	Mental Health Policy Unit, Health

3. Update on review

It was hoped that the framework paper would go before the Cabinet on the day of the RAC meeting (June 20) however this has now been postponed until July 5 which has slightly

altered the review timeline, but the aim remains to have working groups finalised and commencing by late June.

4. Setup of Working Groups

Nominations for Working Groups are ongoing but should be finalised around 24 June. Working Groups should ensure core representation and ideally be composed of around 8 representatives. Heads of Agencies have also been contacted to nominate other expertise for the Groups. The Working Groups will focus on the following subject areas:

- Decision Making Capacity
- Children and Youth
- Advanced Care Agreements
- Principles and Objectives
- Technical Matters
- Involuntary Physical Care

It was noted that earlier work on the Children and Youth Group will be incorporated into the new Working Groups.

In relation to the Technical Matters Group, there was a query around non-controversial amendments in that they may not require a working group process. The RAC group acknowledged that issues raised for amendment should be of a substantive nature that would require working group input. RAC will determine what is non-controversial. Issues that are non-controversial should be dealt with via PCO.

RAC will serve as a unifying body for working group responses and there should be clear terms of reference for each group. The groups should provide feedback to RAC via processes to be established and RAC will meet once a month to work through feedback.
It was agreed that the next RAC meeting will be in approximately six weeks, and then one month after that.

It was felt by members of the RAC that there should be some caution around agencies who participate in working groups who are outside the RAC. It was felt that 'outside' participants will need to have an understanding of the framework of RAC and knowledge of the previous and background issues that have lead to the current framework and context. It would be disadvantageous to have to start discussions from scratch when much of the negotiating had been done. In answer to this, it was agreed that Steve could act as a 'guide' for representatives outside the RAC and provide appropriate context for further discussion.

It was also felt that the approved Cabinet Submission (once available) would provide a more detailed framework and context for ongoing discussions.

The issue of clinical participant involvement was raised and it was felt that timely input from the clinical sector was vital in context of the Cabinet Submission/framework before legislation.

ACT Government Health

Review of the ACT Mental Health Act
Review Advisory Committee

ANNOTATED AGENDA

Monday 25 July 2011

Conference Room, 3rd Floor 11 Moore Street

10:00 – 11:30am

No	Item	Responsibility
1	Welcome	Ross O'Donoughue
2	Apologies	
3	**Overview of work of Forensic MH Working Group** Time has elapsed and membership changed since the Forensic Working Group met, and there has been a request for an overview of the groups work. Check MHACT representation on the Working Group.	Victor Martin
4	**Feedback from other Working Groups, advice and suggestions from RAC :** (Note: Cab sub signed off 5 July (since last RAC) People were notified by email.) **Children and Young People** Has recommendations including age and maturity framework for C&YP to take responsibility for their own decisions – this may be controversial as JaCS advice is that the framework would override Gillick principle which is the present framework and considered quite workable by some. Open discussion Other recommendations not likely to be controversial **Decision Making Capacity** Discussion centres on how the flow of assessment can be set up by the Act to give the best result, and to inform a review of the use of this criterion at a date to be set. Group not yet ready to make a recommendation. Feedback from RAC would be useful (or they may direct the decision). I will give an overview of the discussion (see flow chart)	Steve Druitt

	Principles and Objectives Close to being finalised. Draft circulated and comments welcome. Will give outline. **Advance Agreements** Good progress but giving legal force to the persons wishes to EXCLUDE certain treatment options is currently a slight sticking point, even though this happens in the medical area (it would also put the Act ahead of the recognition of AAs in Mental Health ACT, but it can be argued that this is because further recognition of AAs awaits a revised Act). Feedback to the working group from RAC would be good. Advice also being sought from JaCS. **Technical Matters** Good progress and numerous recommendations made – hopefully there will be time for RAC discussion and feedback, I'll lead the RAC through the handout **Involuntary Physical Care** Has not commenced pending advice from JaCS **Other issues that have arisen** Some other issues have arisen in the course of the teams work that I would like to touch on if there is time, including feedback from ATODs	
5	**Future meeting dates and times** Need to set monthly meetings to end of year, and identify least worst time and day	Ross O'Donoughue

RAC 25Jul2011 – Steve notes

Forensic

- Options paper 2009, submissions till Mar 2010
- Several community submissions received
- Would ideally like 3-6 months to write drafting instructions
- Needs to go to Cabinet December 20111
- Need to reconstitute writing group
- Need for plain language version to be cleared by RAC before writing drafting instructions
- Need to keep writing group small but maintain representation from court/legal area

Children and youth

- Age 14 broadens Gillick (more like 16)
- - pushback from parents
- Clinicians would get signoff from parents
- 14 yo may not even cosign
- 14 yo often given contraception without parental consent
- WG check input from community groups, further consideration, 'age may not be useful', possibility of setting as guidelines or principles

Decision making capacity

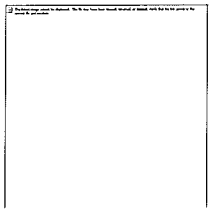
- Also in favour of flow chart of assessment process that it is in the spirit of the reform
- Suggested revised flow chart provided
- Could be supported by an approved form which guides the process
- OK as long as it doesn't make assessment mor drawn out and taxing for the person

Principles and Objectives

- Add that it is a role of the forensic provisions to provide appropriate diversion of forensic mental health clients from the criminal justice system
- A way of incorporating mental health promotion principles in the Act would be to emulate broader health legislation where 'protecting and promoting the health of the population' is listed as a responsibility (of the Public Health Officer – may be DG in the case of MH?)
- Leads to a need for a *definition of treatment* – including regular attendance at appointments, psychotherapy etc (eg WA Act)
- Important whether principle or objective because legislation requires Tribunal and others to be guided by 'purposive interpretation' of the objectives
- Act 'supports clinicians to protect the rights of individuals'

Advance Agreements

- Power to exclude treatment already there under medical directives? Need to seek medical opinion
- Should advance agreements be registered with Tribunal as a way of keeping track? Big task, agreed no



Mental Health (Treatment and Care) Act 1994 Review
Review Advisory Committee

25 July 2011

Conference Room, Level 3
11 Moore Street
Canberra

Meeting Notes

Chair: Ross O'Donoughue

1. Welcome

2. Apologies Denise Caldwell, Sean Costello, David Snell, Pam Jenkins, Sue Watson, Anita Phillips, Trina Bracher, Mary Durkin, Simone Fowlie, John Hinchey, Bill Kerley, Maree Manion

Attendees	
Richard Bromhead	Mental Health Policy Unit, Health
Steve Druitt	Mental Health Policy Unit, Health
Wendy Kipling	Access and Acute Mental Health Services
Trish Mackey	Public Advocates
Peter Norrie	Chief Psychiatrist
Matt Hingston	Human Rights Commission, JACS
Victor Martin	Legislation and Policy Branch, Justice and Community Services (JACS)
Simon Viereck	Mental Health Community Coalition ACT
Linda Crebbin	General President – ACT Civil and Administrative Tribunal
Julia Bocking	Mental Health Consumer Consultant
Anthony Malone	ACT Corrective Services
Herb Krueger	Mental Health Rehabilitation and Specialty Services
Hugh Jorgensen	ACT Magistrates Court
David Lovegrove	ACT Mental Health Consumer Network
Teresa Tuite	Disability ACT
Sara Wade-Vuletic	Mental Health Policy Unit, Health

3. Overview of work of Forensic MH Working Group: Victor Martin

- Given the length of time and change of group membership since the last Forensic Working Group met, it was felt that an overview of forensic issues in the context of

the review was needed. An options paper had been released in 2009 and submissions were accepted until 2010. The group had been ready to prepare drafting instructions.

- The RAC agreed that the working group that had prepared the options paper should reconvene and report to the RAC. It acknowledged that there remained a considerable amount of work to be done and a timeframe of 3-6 months was suggested, however given the brief timeframe for the review (which is scheduled to go to Cabinet in December 2011) the working group will reform and prepare drafting instructions.

- The RAC agreed with the idea of preparing a plain-language draft (Statement of Intention) for consideration by the RAC before drafting instructions (for the Forensic Working group and the other groups).

- The Forensic Working Group will aim to be small but needs to maintain representation from Policing, Human Rights, Health and Mental Health, Community Services, DPP, Judge, Magistrate, Defence Lawyers.

Actions arising:

- Victor and Secretariat would canvas membership for a reconstituted Forensic Working Group and schedule meetings.
- This working group will consider options discussed in previous groups within the current review framework and produce a plain-language Statement of Intent for the consideration of the RAC with a view to preparing drafting instructions.

4. Feedback from other Working Groups, advice and suggestions from RAC: Steve Druitt

Discussion:
Children and young people

Age for making own decisions

- Concern expressed that an age framework may override Gillick, but counter opinion that it would not, the framework suggested may in fact broaden Gillick, which tends to acknowledge DMC at age 16 rather than 14. (Decision making capacity being the crucial factor).
- An age framework could be incorporated as guidelines, while maintaining Gillick, the provisions of the Act could be drafted in such a way that allows for flexibility and a guided framework.
- Aware that in the broader Health environment, 14 yo are at times provided with health services such as contraception without parental consent. At other times parent decides treatment at that age and 14 yo may not even be asked to co-sign.
- Clinicians would get signoff from parents.

- 'Seriousness of the decision' is a factor
- Young people frequently appear before the tribunal (appropriately) for a decision when there is conflict – between treating team and parents, between parents and child or between parent and parent. The working group is asked to consider how the proposed framework may 'play out' using appropriate scenarios.

Actions arising:

- This working group is asked to get input from community groups, further consideration, 'age may not be useful', and possibility of setting as guidelines or principles.
- The group could consult more broadly and in context with other relevant legislation.
- The group is asked to give consideration as to how the recommendations would work in practice.

Decision making capacity (DMC)

- The revised flowchart developed by the working group was generally agreed upon (needs some refinement) and was felt to be in keeping with the 'spirit' of the reform as well as the considerations mentioned (provides data to inform a future review of the use of decision making capacity and encourages uptake of the new criterion by clinicians)
- It was suggested that there may be merit in DMC being assessed singly and first. At a minimum the assessment of DMC and outcome would need to be documented.
- Question whether the flowchart process would add unacceptable time and complexity to assessment but in discussion it was agreed that in the real life assessment situation it would not. It was raised that DMC would occur only for longer-term orders for involuntary treatment and the assessment of DMC would take place within the existing determination period.
- The flow chart process (see attached revised version) could be supported by an approved form which guides the process; as well as gather relevant data necessary to inform a process of enquiry into the efficacy of DMC.

Actions arising:

- The working group was asked to consider how the Act can give greater emphasis to the assessment of DMC as a criterion for making treatment orders.
- The group asked to explain how this assessment will operate in relation to risk and how DMC will work in different scenarios and what obstacles DMC may throw up in practice (e.g. delays, obstructions of people's rights, impact on other legislation etc).