Principles and Objectives

- The revised draft of recommended changes to Principles & Objectives was forwarded to RAC members for comments. The wording of the draft intends to clarify the intent of the Act and drew from similar statements in the revised Mental Health Act of Victoria and Tasmania. The recommendations had the intention to uphold and reinforce rights, of encompass recovery principles and provide a broad context of mental health action including mental health promotion prevention and early intervention (although recognising the ACT is mainly focussed on involuntary treatment).
- It was agreed that a way of incorporating mental health promotion principles into 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 the same or DG in the case of Mental Health?).
- It was suggested that there should be a definition of *treatment* in the definitions section of the Act– this could mention service engagement including, for example, regular attendance at appointments, psychotherapy and recovery (e.g. WA Act)
- It was agreed that principles should include role of the forensic provisions to provide appropriate diversion of forensic mental health clients from the criminal justice system
- The distinction between Principle and Objective was considered to be important in the Act as legislation requires Tribunal and others to be guided by 'purposive interpretation' of the objectives.

Actions arising:

- The RAC felt that consultation with the PCO may be helpful to seek technical advice regarding the Principles & Objectives.
- The Act could be worded to reflect that it 'supports clinicians to protect the rights of individuals'.
- Should Decision Making Capacity be referred to as an Objective of the Act?

Advance Agreements (AAs)

- The working group considered that the provisions of the Victorian exposure Draft and suggestions from Tribunal reflect an effective minimum way of recognising positive treatment preferences of Advance Agreements in the Act. Majority agreement in working group about giving positive preferences legal force (group would aim to achieve consensus on this). RAC supports seeking advice from JaCS
- Health/Medical Directives considered to currently have the legal power to exclude specified mental health treatments (this needs to be checked). Recognised that there needs to be a limit on the legal power but this should be quite circumscribed.
- Issue of consumers wanting advance agreement to treatment to prevail if agreement withdrawn when unwell – RAC view that this would hinge on capacity, that advance

agreement may persuade a person into treatment but if they resisted then the Tribunal would need to make an order.

- Should AAs be registered with the Tribunal as a way of keeping track? It was considered this would be an administrative burden given the number of persons receiving care at any one time, however there needs to be some way of Tribunal receiving notification of a person having a current AA.

Actions arising:

- The working group will need to seek JaCS opinion and the Health Directives Act to confirm whether power to refuse treatment provisions apply to Mental Health treatment. Also regarding positive choices.
- The working is group asked to consider whether there should be Tribunal authorisation for an AA.
- The working group is asked to consider what (if any) risks may exist for those imposing treatment.

Technical Changes

- These notes will be forwarded to the RAC for email feedback, please

Review of the ACT Mental Health Act
Review Advisory Committee

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	Victor Martin
4	Feedback from Working Groups, advice and suggestions from RAC : Children and Young People Decision Making Capacity Principles and Objectives Advance Agreements Technical Matters Involuntary Physical Care	Steve Druitt
5	Future meeting dates and times	Ross O'Donoughue

Review of the ACT Mental Health Act Review Advisory Committee

AGENDA

Friday 2 September 2011

Conference Room, 3rd Floor 11 Moore Street

9:30 – 11:00am

No	Item	Responsibility
1	Welcome	Ross O'Donoughue
2	Apologies	
3	Feedback from Working Groups, advice and suggestions from RAC :	
	Decision Making Capacity	Shirley-Anne Brandon
	Technical Matters	Matt Hingston
	Children & Young People	Steve Druitt
	Advance Agreements	Christine Waller
	Principles & Objectives	Simon Viereck
4	Future meeting dates and times	Ross O'Donoughue

Review of the ACT Mental Health Act - Review Advisory Committee

MEETING NOTES

Date: Friday 2 September 2011, 9:30 – 11:00am

Venue: Conference Room, Level 3
11 Moore Street
Canberra

Chair: Ross O'Donoughue

1. Welcome attendees
Richard Bromhead
Steve Druitt
Linda Crebbin
Trish Mackey
Victor Martin
Stephanie Button
Simon Viereck
Bill Kerley
Sue Watson
Anita Phillips
Renate Moore
Vera van de Velde
Kerry MacDermott
Matt Hingston
Patricia Mackey
Richard Bromhead
Christine Waller
Dalane Drexler
Shirley-Anne Brandon
Velda Hunter

2. Apologies
Len Lambeth
Hugh Jorgensen
Peter Norrie
Bernadette Micherson
Herb Krueger
David Lovegrove
Kate Staric,
Sean Costello
David James
Mary Dirkin
Barry Folpp
Simone Fowlie
Cathy Fox

3. Feedback from Working Groups, advice and suggestions from RAC	
Decision Making Capacity Shirley-Anne Brandon	In addition to the meeting paper - '*Notes for the Decision Making Capacity Working Group 24 August 2011*', Shirley-Anne Brandon tabled the paper '*Input from the Decision Making Capacity Working G in relation to consumers with an intellectual disability*' (at Attachment A). This paper outlines three specific issues regarding informed consent, it includes extracts from the *Guardianship and Management of Property Act (1991)* and the *Mental Health Treatment and Care Act (1994)* (the MHA), and a report entitled '*The Bournewood Case*'. Lengthy discussion by the RAC centred on revisiting the diverse positions and opinions regardingthe management, clinical and legal oversight for people with intellectual disability/dementia/ABI (referred to in Issue 1 of Attachment A) who

	have a diagnosed mental illness, who lack decision making capacity, but who are compliant with the required treatment and people (refered to in Issue 2 of Attachment A) with intellectual disability/dementia/ABI who do not have a diagnosed mental illness but who are prescribed psychiatric medications, and/or who are restrained, detained, or provided with treatments. While the need for a review of Acts of law that are associated with the MHA was recommended in the recent Cabinet Submission, there were views expressed in support of this, or in support of maintenance of the status quo. There was broad consensus that 'Bournewood' clients who may be eligible for a Psychiatric Treatment Order should be the subject of more voluntary provisions outside the Mental Health Act, in guardianship or other legislation but which legislation was not agreed. The pros and cons of the Senior Practitioner model in Victoria (which provides best practice guidance and monitoring of treatment to clients referred to in Issue 2) were discussed, and the possibility that this model could potentially encompass monitoring of consent issues. Issue 3 was briefly discussed with opinion provided around what constitutes consent for intellectually disabled clients, who for example may recognise the benefits of one treatment over another without having a more comprehensive understanding. In summing up, Ross O'Donoughue said that general principle to today's meeting was to focus on the policy intent and input towards development of drafting instructions. The principles and policy intent will be articulated into law.
Technical Matters Matt Hingston	Matt Hingston reported on the activities of the Technical Matters Working Group, and provided further details to some specific items in the meeting paper – '*Proposed technical changes to the ACT Mental Health Treatment and Care Act (1994)*'. This paper provides discussion on the content of various items within the MHA that are recommended for amendment. A plain language explanation is included, as is the reason for proposed changes, and recommendations. It was reported that issues related to a number of items were not resolved as it indicated in the paper. The RAC topics that were discussed regarding items in the paper included: Issues with forensic order detentions in the Psychiatric Services Unit (PSU), as this is not a secure facility; • The benefits and drawbacks of various permutations of timelines for emergency orders and extensions; • The burden of work for the Tribunal, • The relationship of PTOs and the average lengths of stay in the PSU; • The arguments for and against the extension of the maximum length of PTOs from six to twelve months; Steve Druitt would seek further feedback and report back to the RAC regarding extended emergency detention and the possibility of a 12 month order where indicated (It was noted that this will require a robust review process) There was support for the remainder of the technical changes presented
Children & Young People Steve Druitt	Item deferred to the next meeting.
Advance Agreements Christine Waller	Item deferred to the next meeting.

Principles & Objectives Simon Viereck	Item deferred to the next meeting.

4. Future meeting dates and times	
Ross O'Donoughue	RAC agreed to a meeting on 16 September to continue work on current agenda. To follow with the meeting scheduled for 30 September 2011.

RAC Meeting – Review of the Mental Health Act 2 Sept 2011

Input from the Decision Making Capacity Working Group in relation to consumers with an Intellectual Disability

ISSUE 1:

Currently, if a consumer is unable to give informed consent (eg. due to the presence of intellectual disability, ABI, dementia), their legal guardian is unable to consent to treatment (eg. medication) for a diagnosed mental illness.

In accordance with current legislation, these consumers require a Psychiatric Treatment Order (PTO) to enable the ACT Civil and Administrative Tribunal to provide the necessary consent for treatment.

1(a) How many General Practitioners are aware of this legislative requirement?

How many GPs would abide by the legislation if they knew about it?

ISSUE 2:

There are many consumers in the community who cannot give informed consent (eg. due to an Intellectual Disability) who have <u>not</u> been diagnosed with a mental illness, but who are being prescribed antipsychotic medication for the purpose of 'behaviour management'. There is currently no legislative/specialist oversight for these consumers.

2(a) Office of the Snr Practitioner model? Theory vs practical application .....

ISSUE 3:

Informed Consent – where is the line drawn and who draws it?

Eg. If a consumer (with a mild intellectual disability) cannot clearly relate the specific names or purposes of medications which treat a mental illness, however they are able to recount how they know it keeps them well, that they would get sick without it, recount how the medication the previous Dr had them on didn't work as well and also have a clear ability to protest ..... does this constitute 'informed consent'??

CURRENT LEGISLATION

Guardianship and Managment of Property ACT 1991

Section 70 ACAT may consent to prescribed medical procedures

(1) If ACAT has made an order under section 69 (2) in relation to a person, it may, on application, by order, consent to a prescribed medical procedure **(other than treatment for mental illness, ECT or psychiatric surgery)** for the person if it is satisfied that –
   (a) The procedure is otherwise lawful; and
   (b) The person is not competent to give consent and is not likely to become competent in the foreseeable future; and
   (c) The procedure would b in the person's best interests; and
   (d) The person, the guardian and any other person whom the ACAT considers should have notice of the proposed procedure are aware of the application for consent.

Note ***Treatment for mental illness, including electroconvulsive therapy and psychiatric surgery, is dealt with in the Mental Health (Treatment and Care) Act 1994.***

Dictionary (p 52)

Prescribed medical procedure means –

(a) ....(e) ....

(f)-.....treatment for mental illness, electroconvulsive therapy or psychiatric surgery; or

Mental Health Treatment and Care Act (1994)

Division 4.4 Psychiatric Treatment Orders

The ACAT may make a psychiatric treatment order in relation to a person it –

(a) The person has a mental illness; and

(i) The ACAT has reasonable grounds for believing that, because of the illness, the person is likely to –

(ii) Do serious harm to himself, herself or someone else, or

(iii) Suffer serious mental or physical deterioration

(b) The ACAT is satisfied that psychiatric treatment is likely to reduce the harm or deterioration (or the likelihood of harm or deterioration) mentioned in para (b) and result in an improvement in the person's psychiatric condition; and

(c) 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

You are in: ResourcesExpert Guides

The Bournewood Case

Wednesday 02 September 2009 11:22

Bournewood: the case

The Bournewood case started in July 1997 when a 49-year-old severely autistic man, known as HL, who could not speak, was admitted to Bournewood psychiatric hospital, Surrey, after becoming distressed at a day centre.

When the day centre staff were unable to contact HL's carers (Mr and Mrs E) and could not contain the situation, a GP tried to calm him down with medication. When this didn't work the GP referred him to the local hospital where he was seen by a psychiatrist. The psychiatrist couldn't tell whether HL had a psychiatric condition or behavioural problem, so decided to admit him for observation. When he was discharged just over four months later, his carers claimed HL looked like "someone out of Belsen".

Court rulings

While he was in hospital, Mr and Mrs E began legal proceedings over his detention. After failing in the High Court, they went to the Court of Appeal, which backed them in December 1997, ruling that the informal admission to hospital was unlawful, even though he was incapable of agreeing to or refusing treatment.

The Bournewood Community and Mental Health NHS Trust sectioned HL after this ruling, before releasing him in December 1997 with a care plan and monitoring arrangements.

The House of Lords then overturned the Appeal Court's decision in June 1998 and found in favour of the hospital – now backed by the Department of Health. This ruling had huge implications as it ended the situation where people with conditions such as Alzheimer's, dementia or learning disabilities would have to be sectioned under the Mental Health Act 1983 before being admitted to care for short periods of treatment.

A subsequent health service ombudsman report in 2002 found that the NHS trust should not have detained HL, saying that even if it felt it was right to keep him overnight "it is difficult to see why he was not discharged the next day. Any further assessment could have been conducted in the community".

European Court of Human Rights' verdict

Mr and Mrs E then took their case to the European Court of Human Rights, which ruled in October 2004 that HL had been deprived of his right to liberty under article 5 of the human rights convention. HL had not been detained under the Mental Health Act 1983, instead he was accommodated in his own "best interests" under the common law doctrine of 'necessity'. The European court held that this doctrine was too arbitrary and lacked the safeguards provided to those sectioned under the Mental Health Act.

Serious case review

Mr and Mrs E then wrote to Surrey's adult protection committee in August 2005 asking for an independent review into HL's treatment. This was finally published in September 2008, although much to the couple's disappointment only the summary was made public.

The serious case review found that HL's period in Bournewood had "resulted in an adverse effect upon his physical condition"; his detention was unnecessarily long and community-based alternatives had not been considered; and that the "system" did not allow it to be challenged.

It also said that if the detention happened today it could be investigated as potential professional abuse under Surrey's multi-agency safeguarding procedures "due to alleged misuse of therapeutic powers".

But it added: "Given the widespread practice at the time, applying today's criteria to what happened then, it is unlikely it would have been found to have been professional abuse."

Closing the "Bournewood gap"

The numbers of non-compliant patients being held against their will is unknown, but in a consultation between March and June 2005 to seek views on potential ways to close the "Bournewood gap", the government estimated it could be as many as 50,000 of those permanently admitted to care homes and 22,000 hospital in-patients.

The consultation resulted in the introduction of safeguards for people who lack capacity and are detained for treatment or care. The deprivation of liberty safeguards, which come into force in April 2009, provide a framework for authorising and challenging detentions.

The Mental Health Act 2007 - as well as amending the Mental Health Act 1983 - was used as the vehicle for introducing deprivation of liberty safeguards into the Mental Capacity Act 2005. The safeguards will strengthen the rights of hospital patients and those in care homes, as well as ensuring compliance with the European Convention on Human Rights.

The safeguards include:

- A third party, such as a relative or carer, can request an assessment of whether or not a person is being deprived of their liberty.
- Anyone who does not have family or friends who can be consulted will have an Independent Mental Capacity Advocate instructed to support and represent them during the assessment process. IMCAs will also be a right for those whose representative or supervisory authority believes it is necessary.

Related articles

Community Care's interview with Mr and Mrs E

Bournewood carers safeguard criticism

Serious case review granted over treatment of man at Bournewood

Lawyers set to test 'Bournewood' rules

The Bournewood Case

Bournewood carers urge government to improve protection for mental health patients

Authorities must consult in cases of urgent detention

Bournewood serious case review is criticised by HL's carers

Further information

Mental Capacity Act 2005

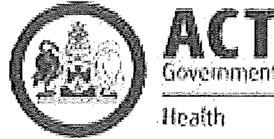
Summary of Surrey's serious case review

Review of the ACT Mental Health Act
Review Advisory Committee

AGENDA
Friday 16 September 2011

Conference Room, 3rd Floor 11 Moore Street
9:30 – 11:00am

No	Item	Responsibility
1	Welcome	Ross O'Donoughue
2	Apologies	
3	Feedback from Working Groups, advice and suggestions from RAC : Children & Young People Advance Agreements Principles & Objectives Updates from other areas (time permitting)	 Steve Druitt Christine Waller Simon Viereck
4	Future meeting dates and times	Ross O'Donoughue



Review of the ACT Mental Health Act
Review Advisory Committee

ANOTATED AGENDA
Friday 16 September 2011

Conference Room, 3rd Floor 11 Moore Street
9:30 – 11:00am

No	Item	Responsibility
1	Welcome Welcome to Christina Ryan from Advocacy for Inclusion. we're doing what we can to make up for your late invitation to this process	Ross O'Donoughue
2	Apologies	
3	Feedback from Working Groups, advice and suggestions from RAC : Children & Young People (Currently have two alternative recommendations for when young people can make their own treatment decisions) Advance Agreements These recommendations have been held up awaiting advice from JaCS but Richard and I have a meeting with JaCS Thursday 14 Sept pm. Principles & Objectives Updates from other areas (time permitting)	 Steve Druitt Christine Waller Simon Viereck
4	Future meeting dates and times	Ross O'Donoughue

Review of the ACT Mental Health Act Review Advisory Committee

MEETING NOTES

Date: Friday 16 September 2011, 9:30 – 11:00 am

Venue: Conference Room, Level 3
11 Moore Street
Canberra

Chair: Ross O'Donoughue

1. Welcome attendees
Richard Bromhead
Steve Druitt
Christina Ryan
Sue Watson
Victor Martin
Julia Bocking
Bill Kerley
Dalane Drexler
Renate Moore
David Lovegrove
Matt Hingston
Christine Waller
Dalane Drexler
Sean Costello
Peter Norrie
Simon Viereck
Denise Caldwell
Christina Thompson
Velda Hunter (Secretariat)

2. Apologies
Linda Crebbin
Barry Folpp
Simone Fowlie
Cathy Fox
Margaret Ford
Katrina Bracher
Vera Van De Velde

1 and 2 Welcome and Apologies

Ross O'Donoughue welcomed to Christina Ryan from Advocacy for Inclusion

3 Feedback from Working Groups

Children and Young People
Steve Druitt

- The Working Group (WG) will continue work on a decision regarding two alternate recommendations for when children and young people can make decisions regarding their own treatment, and the RAC may be asked to assist with the final decision. The proposed alternatives are:

  1. Gillick Competence which holds that *"As a matter of Law the parental right to determine whether or not their minor child below the age of sixteen will have medical treatment terminates if and when the child achieves sufficient understanding and intelligence to understand fully what is proposed."*; or

  2. Age Related Framework:

I. 8th B'day - under 14	1. Should be involved in decisions regarding treatment and major decisions regarding their care
II. 14th B'day – under 16	2. The young person can be assessed for decision making capacity from 14th birthday. 3. If the young person is assessed as having decision making capacity and gives informed consent to treatment their decision should be given greater weight at this age.
III. 16th B'day – under 18	4. If the young person has capacity, and they give informed consent, their decision should prevail. 5. If the young person is assessed as having decision making capacity and does not consent to treatment, their decision should prevail unless there is a high risk of harm to others, or to self including risk of serious deterioration in mental health.

- Electroconvulsive Therapy (ECT) and young people. The WG recommends that ECT be retained for the very rare cases when it is the recommended treatment. A member of the WG is currently researching legislation regarding the requirement to procure second opinions before ECT is undertaken. The RAC recommended ACAT involvement in ECT decision making for young people to ensure the oversight, and resolve question and community concerns regarding capacity. RAC asked that the working group recommend on the age at which ACAT be involved.

- Issues being discussed by the WG regarding forensics and young people include:
  1. Sharing of information;
  2. Amendments to the legislation to enable a treating doctor to recommend the transfer of young person from prison to a health facility; and
  3. The recommendation to accommodate acutely mentally unwell young people within health, rather than in prison facilities. However, the making of legislation in anticipation of the commissioning of a new facility will need to consider the availability of suitable accommodation.
- The Children and Young People WG will meet again next Friday 23 September 2011.

Advance Agreements Chris Waller	The RAC was guided through the Advance Agreements (AA) paper that was circulated. Points of discussion included: • RAC considered some issues that were raised regarding the wording in the draft AA; • Recommendation to remove the words '*by a mental illness*' from the draft AA; It was recommended that legal advice be sought to ascertain whether AA were in conflict with documents such as Enduring Power of Attorney or Guardianship, and what if any, implications resulted; • It was recommended that a questioning regarding Enduring Power of Attorney be routinely included when AAs are drawn up with consumers; • The recommended review time of 12 months was discussed, in particular if the AA is for use by people with disability and the capacity is not restored over time; • It was stated that the review of the AA was intended to parallel the recovery pathway; • There was discussion as to whether the draft AA could be utilised by people with disability as well as by those with mental illness, and whilst it was acknowledged that it would be useful for one framework to serve both groups, it would be difficult to achieve this as these groups differed too greatly. It was suggested that the AA was intended for persons with mental illness only; AAs might be used in the disability sector if people have capacity but it is foreseen that they will lose it, but note comment above – need to allow consideration of AAs past 12 months in this sector. • In summing up these arguments, the Chair conjectured that there are distinctions to be included in a legal framework for each cohort if AAs are introduced into the revised MHA, and that it was the role of the RAC to provide advice for the drafters in the Parliamentary Council Office; • There was discussion regarding the option to revoke AAs only if document were agreed and signed as all other instances, contracts can be altered verbally; • It was agreed that where a PTO or CCO was made, the AA should be suspended for a specified period, • RAC was advised re issues for discussion at the next meeting of the Advance Agreements WG: o the Public Advocate would provide input regarding options for over-riding AAs in cases of emergency detention; and o Victor Martin would provide input re fineable offences in Section 20 of the *Medical Treatment (Health Directions) Act 2006.*
Principles and Objectives Simon Vireck	• In general members provided positive feedback on the paper that was circulated; • RAC agreed that the word 'recovery' be reordered to the top of the list (not at D); • There was some discussion on the selection of the definition of 'recovery', and RAC was advised that the Principles and Objectives WG is satisfied with the draft, and RAC was reminded that the drafters in the Parliamentary Councils Office would include a definition from those provided and members would have the opportunity to provide feedback on the Exposure Draft. Members were invited to provide alternate definitions.

4 Future meeting dates and times

2011 RAC meetings are scheduled for: Friday 30 September 2011,

Friday 21 October

May be need for and additional meeting between 30 September and 21 October to allow consideration of drafting instructions

Review of the ACT Mental Health Act
Review Advisory Committee

ANOTATED AGENDA

Friday 30 September 2011
Conference Room, 3rd Floor 11 Moore Street
9:00 – 10:30am

No	Item	Responsibility
1	Welcome	Ross O'Donoughue
2	Apologies	
3	Involuntary Physical Care Update Members have been sent PAs 3 submissions and dot points from me on the issues they raise. They have the following summary of GSO advice: Options "Advice sought from Government Solicitors Office (GSO) has supported aspects of the Public Advocates interpretation of law on involuntary physical care, but commented that some law of other jurisdictions was open to other interpretation. GSO also pointed out that where written law replaces common law it should be interpreted narrowly. GSO advice is confidential and the document cannot be released at this time. Regarding the Public Advocates comment on the issue of power to enforce involuntary treatment, GSO has advised that enforced involuntary treatment can continue, and they will be providing further advice." I think RAC need to discuss this, but we may also need to recall the Involuntary Physical Care working group	
4	Updates/Feedback from Working Groups, advice and suggestions from RAC : Forensic Mental Health Victor will give an overview of progress Other Working Groups	 Victor Martin Steve Druitt

	Decision Making Capacity has recommended guardianship options for Bournewood clients, with PA support. Guradianship options are seen to require a higher level of oversight than current provisions. Information being collected from other states However, Bournewood is quite broad and may need something in the act about always considering decision making capacity. This has big implications in MH and bigger implications in disability. OK to ask RAC for a direction on this? Technical changes has new options for extending emergency detention which will need discussion Children and Young People – awaiting info from Victoria on ECT and children	
5	Future meeting dates and times	Ross O'Donoughue

Review of the ACT Mental Health Act
Review Advisory Committee

MEETING NOTES

Date: Friday 30 September 2011
Time: 9.00 – 10:30 am
Venue: Level 3 Conference Room
11 Moore Street

Chair: Ross O'Donoughue

1.Welcome attendees

Richard Bromhead
Steve Druitt
Christina Ryan
Sue Watson
Victor Martin
Renate Moore
Linda Crebbin
Renate Moore
Delane Drexler
Matt Hingston
David Lovegrove
Sean Costello
Simon Viereck
Denise Caldwell
Rosemary Kenna
Jessica Brenner
Greg Booth
Wendy Kipling
Velda Hunter (Secretariat)

2. Apologies

Kate Starick
Bill Kerley
Barry Folpp
Simone Fowlie
Cathy Fox
Margaret Ford
Katrina Bracher
Vera Van de Velde
Peter Norrie
Christine Waller
Julia Bocking

Welcome	
Ross O'Donoughue	The chair acknowledged the Traditional Owners, the Ngunnawal people.
2. Attendance and apologies.	
Ross O'Donoughue	RAC members were welcomed.

3. Involuntary Physical Care Update	
Steve Druitt	Steve Druitt led the RAC in a lengthy discussion that centred on the paper '*Involuntary treatment of physical conditions for people suffering mental health conditions and/or having incapacity, including the use of restraint*' that was drafted by the Public Advocate, and circulated to RAC members yesterday. The RAC expressed concerns about the paper, issues raised were: • There had been insufficient time for RAC members to consider details of the paper, and may not be time to adequately consider the issues within the timeframe of the review; • The paper's interpretation of mental health legislation of other jurisdictions was too broad; • The RAC advocated for the management of involuntary physical treatment to be succinctly articulated, ensuring that Cabinet was granted the option to closely consider all implications so that future decisions should not made through reading meaning into the MHA, thus leaving openings for unintended interpretation; • Psychiatrists are currently often asked to place people in the general medical environment under the MHAct for involuntary treatment physical conditions. This can't be done presently because the Act doesn't cover physical treatment, but there is also a broad view that it is not the purpose of mental health legislation. However because the ACT Act also covers mental dysfunction, a change enabling orders to cover involuntary physical treatment would have universal application unless otherwise restricted ; • The NSW MH Act was recommended as meeting the criteria for improving treatment of physical conditions in persons with a mental illness. • Representatives from Policing ACT requested clear definitions to ensure that police can act to affect positive outcomes within the remit of their role. Action: Reconvene the Involuntary Physical Care Working Group. Date and time to be advised.
4. Updates and feedback from working groups, and vice and suggestions from RAC: 4.1 Forensic Mental Health	
Victor Martin Paper for the secretariat.	Victor Martin advised the RAC on the progress of proposals for the forensic provisions under the new Act. The Forensic Mental Health WG has now met twice since being reformed. Whilst there have been no specific agreements at this time, the WG is aiming to provide a set of propositions for RAC consideration of a comprehensive framework for mental health orders covering the first charge to provisions in the Magistrates or Supreme Courts, and cover leave and release from facilities, lifting of an order, and transfer to other jurisdictions. The proposal will include a set of orders ('Forensic orders') that mirrors the PTO or CCO scheme that are either facility or community-based, that takes into account the considerations for protection of the community by the ACAT. Consideration is also being given to the sharing of information, participation and input into ACAT processes. RAC were also advised that the WG work refines what already exists that is poorly understood, or lacks clarity, and will clarify if the work of the ACAT is purely therapeutic or protective.

	Topics for recommendations in the WG paper include: • Objectives and Principles – regarding restriction, community safety, provision of care, treatment and support. • Fitness to plead and mental impairment changes to the *Crimes Act 1900* • Forensic Orders to include a new scheme with four broad categories • Provisions for the sharing of information by the ACAT to a primary carer, the Guardian or attorney. • The right of affected persons through amendments to the *Victims of Crime Act 1994*. The WG will meet again on 17 October 2011 to refine material for RAC.
4.2 Other Working Groups 4.2.1 Capacity Working Group	
Steve Druitt	Steve Druitt advised the RAC the WG was continuing to consider the Bournewood judgement, and reported that the Public Advocate had assisted with the recommendation that psychiatric treatment should no longer be a prescribed treatment under the *Guardianship and Management of Property Act* (GMPA) when the Guardian can make a decision. WG is looking at recommendations to increase the level of oversight in guardianship for this group similar to an order The WG recommended that Enduring Power of Attorney be extended to people with mental illness. The project leader raised the issue that decision making capacity has not historically been intrinsically considered in mental health or mental dysfunction, and the 'Bournewood' situation was quite broad in both areas. He proposed a principle in the Act for decision making capacity always to be considered in assessment, compliance not to be taken as consent, and an authorised capacitous person required to make treatment decisions. There was no objection to the principle, although it was noted that the task of oversighting this provision would be quite large, especially in mental dysfunction. The issue of a need to recognise supported decision was raised, but there was concern about adequate time for consideration in the timeframe.
4.2.2 Tech Matters WG	
Steve Druitt	Emergency Detention – Feedback from canvassed workers including Tribunal, Tribunal Liaison, Duty Lawyers and from RAC was overwhelmingly negative on reducing the notice for application for orders to 1 day. There was interest in the option of a second 11 day order, lapsing to 7 days if not upheld by a second consultant within that time. Linda Crebbin asked for time to consider before commenting; also interest in maintaining status quo.

	Emergency actions (EA) were discussed and it was reported that there was confusion regarding the timeframes of these and when EAs lapse. Issues for policing included requests for transportation of people to TCH as there was a lack of clarity of the timeframes. Proposed timeframe for assessment after arrival was generally supported. The idea of allowing 90 minutes for transport was questioned. As the issue is usually transfer from Calvary to TCH it was proposed that consideration be given to the option of Calvary Drs writing an ED3 instead
5. Future meeting dates and times	
Meetings will be scheduled for: • 14 October 2011 and • 21 October 2011 • Out of session matters will be managed via email.	

Items not reported in RAC 30 Sept 2011

Feedback from Working Groups not covered in 30 September RAC meeting

Advance Agreement (AA) Working Group

- removed provision that binds Tribunal to abide by AA, as Tribunal only decides orders. Tribunal to 'take AAs into account'.

- an order only suspends an AA, and only suspends specific provisions of an AA. The AA is automatically reinstated when the order lapses or is revoked, if this is within the valid time of the AA (12 months).

- Tribunal to check of existence of an Enduring Power of Attorney (EPA) or guardianship order. (recommend that AA include whether there is an EPA or guardianship order in existence)

- AA which lapses due to the persons lack of decision making capacity continues to be a document to take into account when planning treatment and considering involuntary orders. The treating doctor must document reasons where the AA provisions are not followed. (There may need to be a provision for longer term AAs where there is enduring incapacity.)

Child and Young Person Working Group

- general support for Gillick Principle to guide when young people can make own treatment decisions. Group recommends that the Gillick Principle be enshrined, rather than that MHAct be silent on the issue. Views of significant others should always be taken into account.

- The group asked for more information from the review of ECT in Victoria before making a final recommendation regarding ECT for people under 18.

  Forensic provisions for children and young people

- That the Act state that all efforts should be made to accommodate acutely mentally unwell young people who are forensic clients in a mental health facility.

Suggested points for consideration regarding provisions for involuntary physical treatment

Steve Druitt, Review Project Leader 29 Sept 2011

The ACT context differs in two important ways:

- The Mental Health Act provides for mental dysfunction
- There is a Human Rights Act

In this context we need to consider what our intent in the physical treatment area.

- Because the ACT Act covers mental dysfunction, providing for involuntary physical treatment under the MH Act will (unless otherwise restricted) make all people for whom involuntary physical treatment is considered, including people in the general health environment who have had no connection with mental health services, such as people who have had a motor vehicle or other type of accident or may be suffering delirium because of fever, eligible for an involuntary order. It seems an unwarranted extension of mental health legislation to cover all these circumstances. Many people would presumably have strong objections to being placed under mental health law for these purposes.

- Decision making capacity about mental health treatment does not coincide with decision making capacity about physical treatment. People will frequently, perhaps usually have capacity to make their own physical treatment decisions. A 'generic' order for treatment is not likely to be seen as human rights compliant. They are separate determinations.

- What are the reasons a person with mental illness would require substituted decision making about their physical health care? Often they will have nothing to do with their mental illness – there are the same range of reasons as for a person who does not have mental illness – eg unconscious, delirious, dementia.

- The reasons may also be related to the mental illness, eg eating disorder, delusional state, deficit of self care. In this case the opinion of a psychiatrist may be useful in determining the persons decision making capacity when considering an order (whether a MH order or guardianship).

- Physical health care is conducted in the physical health care system. It is arguable that the process for substituted decision making needs to occur in the physical health care environment, with people who are expert in the persons condition and familiar with their physical history (Possibly with input from psychiatry about the impact of M=mental illness on the persons capacity). Expertise on physical health care is often not current in the psychiatric system.

- There is a strong push to have the physical health care of people with mental illness attended by physical health specialists in a general health environment, rather than as a secondary consideration in the mental health environment. (This is part of the rationale for having mental health assessment in Emergency Department, and initiatives to reengage people with enduring mental illness with GPs). Having decisions about involuntary physical treatment made under the Mental Health Act may undermine this purpose.

- Most substituted decisions about physical care are made under guardianship and some eg Queensland, are enforceable.

- Should substituted decision making about physical care be different because the person has a mental illness?

- Is it a backward step, when we are moving mental health legislation towards a guardianship model, to move substituted decisions about physical treatment out of guardianship into mental health legislation?

For the review

Need to clarify existing provisions and consider the range of options for addressing them (reconvene Involuntary Physical Treatment group?)

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

Forensic Mental Health Working Group

Recommendations to the Review Advisory Committee

1. Introduction

The recommendations set out below are premised on options set out in the Forensic Mental Health Options Paper (Options Paper) released in November 2009. Five submissions were received from government and non-government agencies. Submissions received have informed the development of the recommendations set out in section 2.

The Options Paper noted that a number of provisions relating to forensic mental health patients already exist and in many respects remain conceptually sound. The tenor of the Options Paper was to support the appropriate treatment, care and support for forensic patients in either the community or an appropriate treatment or care facility.

It is important to note at the outset that the recommendations are premised on obligations set out in relevant national and international instruments. Principle among these is the ACT *Human Rights Act 2004* (HRA).

1.1 Rights as a foundation for forensic law in the ACT

The HRA enshrines a number of human rights principles and the cornerstone of them are the principle of equality and non-discrimination (section 8 of the HRA). The specific human rights contained in the HRA which are directly relevant to forensic patients in the Territory ('forensic mental health rights') are in Part 3 — which enshrines in the ACT *the International Covenant on Civil and Political Rights*. These include:

- non-discrimination and equality before the law (section 8);
- protection from torture and cruel, inhuman or degrading treatment or punishment (section 10);
- protection of children (section 11(2));
- right to privacy (section 11);
- right to liberty and security of person (section 18);
- humane treatment when deprived of liberty (section 19);
- children in the criminal process (section 20); and
- rights of the criminally accused (sections 21 through 25).

Other relevant international instruments include:

- the *Convention on the Rights of Persons with Disabilities*
- the *Convention on the Rights of the Child*
- the *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*

- *Principles for the protection of persons with mental illness and the improvement of mental health care.*

The *World Health Organisation Resource Book on Mental Health, Human Rights and Legislation* (WHO Resource Book), in discussing the prevalence of people with a mental illness in prisons provides the following:
Mental health legislation can help to prevent and reverse this trend by diverting people with mental disorders from the criminal justice system to the mental health care system. Legislation should allow for such a diversion at all stages of the criminal proceedings — from the time a person is first arrested and detained by the police, throughout the course of the criminal investigations and proceedings, and even after the person has begun serving a sentence for a criminal offence.

The WHO Resource Book sets out a useful framework for the development of legislative provisions for the management, including appropriate diversion, of mentally ill offenders. This WHO framework guides the following recommendation and with the HRA and international human rights instruments will form one of the foundation of new forensic mental health legislation in the ACT.

The framework posits that the four stages at which an arrested person can be diverted to mental health admission and treatments are described as:
- pre-trial stage;
- trial stage;
- post-trial (sentencing) stage;
- post-sentencing stage (post serving prison sentences).

As a result, mechanisms will be created to allow for the making of involuntary community or facility based orders with specific application to a class of persons.

2. Recommendations

2.1 Objects and Principles

The Objects and principles for the civil provisions of the Mental Health Act will apply to the forensic provisions.

The following principle is to apply to the ACT Administrative and Civil Appeals Tribunal when considering a matter relating to a forensic patient:

(a) "Restrictions on a person's freedom and personal autonomy should be kept to the minimum consistent with the safety of the community."
Refer - section 39 Principle to be applied *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Victoria)

The following objects shall apply to forensic provisions:
(a) to ensure the safety of members of the community,

(b) to provide for the care, treatment and support of persons subject to criminal proceedings who living with a mental illness or mental dysfunction,
(c) to facilitate the care, treatment and support of any of those persons in a correction centre or youth detention facility through treatment orders,
(d) to facilitate the provision of in-patient care or care in the community through treatment orders for any of those persons who require involuntary treatment,
(e) to give an opportunity for those persons to have access to appropriate care.

(refer section 40 of the NSW Mental Health Act)

2.2 Fitness to plead and Mental Impairment

Retain the existing provisions for fitness to plead (in the *Crimes Act 1900*) and mental impairment (in the *Criminal Code 2002*).

Amend the Crimes Act to require the court:

- to allow an affected person to provide a statement when considering the imposition of a limiting term or release of a person to either unconditionally or subject to the jurisdiction of the ACAT;
- to advise in its orders how it has taken into consideration an affected person's statement.

Retain other existing provisions relating to the setting of a limiting term.

2.3 Forensic orders

A new scheme of forensic orders will apply to persons under four broad categories.

1. Where a person's charge is dismissed and the person is referred to the ACT Civil and Administrative Tribunal (section *Crimes Act 1900*, 334(2)(a));
2. Where the person remains before the court and has been found either temporarily or permanently unfit to plead
3. Where the person is found not guilty by reason of mental impairment and the person is referred to the ACT Civil and Administrative Tribunal;
4. Where a person is remanded by a court in relation a criminal charge or where the person is a serving a custodial or community based sentence.

Forensic orders of the following classes will be made:
Forensic psychiatric treatment orders, either community or facility based orders. These orders will be available where a person has a mental illness;
Forensic care orders, either community or facility based orders. These orders will be available where the person has a mental dysfunction.

The Chief Psychiatrist will be responsible for forensic psychiatric treatment orders and the Care Coordinator will be responsible for forensic care orders

Forensic orders are to be made by the ACAT are to be made on the following criteria:
XXXX

Forensic orders can be made for a period of up to 12 months and can be reviewed at any time on the application of the person subject to the order, by the Chief Psychiatrist or Care Coordinator or own the ACAT's own motion.

An application to the ACAT is required to do the following:

- make a significant change to the treatment or care plan;
- grant leave from a treatment or care facility as part of a care or treatment plan;
- grant leave from a treatment or care facility for a stated purpose;
- release the person from a treatment or care facility into the community; or
- transfer the person to another jurisdiction.

Where the ACAT is considering whether to make a forensic order it must give notice to an 'affected person' to provide an opportunity to make a written submission to the hearing. An 'affect person' will be defined to include a person who would be understood to be a victim of crime in the criminal context (refer to the definition of a victim in section 6 of the *Victims of Crime Act 1994*.

Where the ACAT is considering whether to make or reviewing a forensic order it must give notice the following people to invite to attend the hearing: a carer, Guardian, attorney, the Public Advocate, the Human Rights and Discrimination Commissioner. Where there is an affected person in relation to the person subject to the hearing, the Victims of Crime Commissioner.

2.4 Information sharing provisions

Where forensic orders are made, the legislation will require the ACAT to disclose certain information to a primary carer, the guardian or attorney.
8. The legislation will confirm that government agencies are able to give information to and receive information from other government agencies related to a forensic patient without the person's consent if it is reasonably necessary for the exercise of the agency's functions.
9. The amendments will also allow government agencies to share information with non-government service providers and primary carers where it is reasonably necessary to assist those agencies in the provision of services to a person subject to a forensic order.

2.5 Rights for affected persons

Amend the *Victims of Crime Act 1994* to extend the functions of the Victims of Crime Commission to include 'to advocate for the interests of affected persons'.

The procedural provisions for forensic orders will require an opportunity be provided to the affected person to provided an 'affected person statement' where the ACAT is considering whether to:

- grant leave or the release of a person detained in a psychiatric or care facility, including conditions of release that may be relevant to the affected person;
- make a significant change to a treatment or care plan likely to impact on the affected person.

The legislation will require the ACAT to advise in its orders how it has taken an affected person's views into consideration where such a submission has been provided.

The legislation will require that the affected person be informed as soon as practicable where the person subject to a forensic order absconds.

the Canadian Supreme Court has recently ruled that the lack of access to prompt health care through the public health system could violate the right to life liberty and security of the person under the Canadian and Quebec Charters of Human Rights and Freedoms (*Chaoulli v. Quebec*, 9 June 2005, (2005) SCC 35).

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

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.

Mail PO Box 1001 Civic Square ACT 2608 **Address** Level 3, 12 Moore Street Canberra City ACT 2601
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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.

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- 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

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From: Phillips, Anita
Sent: Tuesday, 13 September 2011 1:30 PM
To: Druitt, Steve
Cc: Bromhead, Richard
Subject: RE: involuntary treatment of physical conditions

Hi Steve

I have had discussions with Peter Norrie, amongst others with regard to the recommendations in this paper, and some policy principles are becoming clearer and receiving support. It would be good if we could integrate these into the RAC agenda at some stage.

With regard to the treatment of physical conditions for persons under a PTO,
Recommend removing the term "psychiatric" (treatment) from the PTO.

1. RAC should consider recommending the removal of the specific reference to "psychiatric treatment" from PTOs. (It might be useful to investigate the history as to why this was included in the first place, as it is not in the legislation of other jurisdictions.)
2. If "psychiatric treatment" were removed from the PTO, this would then allow a medical practitioner to give involuntary physical treatment to a person subject to a PTO, as is already the case with a CCO. (This would remove the necessity for a guardian to give consent to this treatment on behalf of the consumer.)
3. This does not provide a solution to the use of force to provide physical treatment to someone who is not subject to a PTO, but that is outside the RAC deliberations at this stage).
4. There also needs to be a discussion as to whether the ACT moves in line with others by having only one Order for involuntary treatment for someone living in the community – rather than PTOs for mental illness and CCOs for mental dysfunction (which are identical except for the PTO specifically referring to psychiatric treatment).

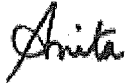
With regard to someone with a decision making disability being able to consent to psychiatric treatment,
Recommend removing the term "psychiatric" (treatment) from the *prescribed medical treatment* list in the Guardianship and Health Attorney legislation.

5. There has been considerable discussion about whether someone under a guardianship order, who appears to understand the medication being prescribed and is agreeable to take it, can consent to this treatment. Such people are often suffering a dual disability, such as an intellectual or dementing condition.

The issue here is that a person under guardianship has been determined by the ACAT as having a decision making disability, based on an assessment of a medical practitioner – often but not always a psychiatrist. Even if someone is compliant with treatment, and appears to understand, the treating medical practitioner is obliged to have regard to the right of autonomy. That is, everyone has the right to give consent that is informed and based on certain principles such as understanding the treatment and the risks, and being able to communicate their consent. A person assessed as having a decision making incapacity has the right to have someone else who does understand, give consent or not, on their behalf.
It is not sufficient for a psychiatrist to believe that a person is compliant and willing to give consent, if that person is under a guardianship order, ie. is suffering from a decision making incapacity. The only way that the psychiatrist can take consent from such an individual, is for them to approach the ACAT and have the guardianship order revoked, so that the person can then consent to treatment themselves.
Currently, if the person is clearly suffering from a decision making incapacity they are entitled to have a substitute decision maker consent on their behalf, but no-one – not guardian or health attorney – can consent to "psychiatric treatment" so we have to revert to the PTO as the only means

of authorising such treatment. If the restriction on "psychiatric treatment" was removed from the Guardianship and Health Attorney legislation, these substitute decision makers could then give consent where a person is willing and agreeable to be compliant with treatment.

Cheers



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Involuntary treatment of physical conditions for people suffering mental health conditions and/or having incapacity, including the use of restraint.

A. Introduction

1. In the ACT a Psychiatric Treatment Order (PTO), is used to authorise the involuntary administration of *psychiatric* treatment when a person is unable to give consent to this,[1] but there is no provision for involuntary treatment of physical conditions. In addition, while a PTO allows the Chief Psychiatrist to authorise confinement and restraint, without limiting this to mechanical means, there is no provision for the use of coercion in the administration of that psychiatric treatment.[2]

2. As a result, while **psychiatric treatments** required, for people with mental health conditions that render them unable to give consent, can be administered involuntarily, **physical treatment cannot**, and **no treatment can be administered with the use of restraint**.

3. This situation causes considerable practice dilemmas. This paper will look at possible solutions from other jurisdictions and guidance from case law to assist in informing changes to the *Mental Health (Treatment and Care) Act 1994 (MH Act).*

B. Background

4. Common law has traditionally protected the right of every individual to complete autonomy for what happens to their own body. International case law from early times has embedded this right that no-one can provide medical treatment to a patient, except in a life or death emergency, unless the person has given consent.[3] This is often referred to as *informed consent* to reflect the essential elements of needing to be voluntarily given, in relation to a specific procedure and communicated by a fully competent adult.[4] However, if a person has been assessed as having an incapacity in relation to understanding the implications of necessary treatment, a substitute decision maker can be appointed to give that consent on their behalf.

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[1] S29(1) *Mental Health Treatment and Care Act 1994* ACT.
[2] Ibid s35(2)
[3] *Schloendorff v Society of New York Hospital* (1914) 211 NY 125
[4] J McIlwraith and B Madden, *Health Care and the Law.* (Thompson Lawbook Company, Sydney 2006).

5. In the ACT there are several categories of possible appointees such as a *Guardian,*[5] or an Attorney under an *Enduring Power*[6] or as a *Health Attorney.*[7] None of these however can give consent for a *prescribed medical procedure*, which includes (f) *treatment for mental illness, electroconvulsive therapy or psychiatric surgery.*[8]

6. Someone who by reason of having been assessed as having an incapacity due to a mental illness[9] or mental dysfunction[10] and is consequently unable to consent to their treatment or care, needs to be subjected to a PTO (if they are suffering a mental illness) or a Community Care Order (a CCO if it is a mental dysfunction) so that their involuntary treatment can be authorised by the Chief Psychiatrist or the Community Care Co-ordinator.

7. Under s 29(1)[11] of the *MH Act,* a PTO can state:

(a) a health facility to which the person may be taken;

(b) that the person must do either or both of the following:

(i) undergo ***psychiatric treatment****, other than electroconvulsive therapy or psychiatric surgery; (ii) undertake a counselling, training, therapeutic or rehabilitation program.*

8. Under section 36A(1)*[12]* of the *MH Act,* a CCO can state that the person:

(a) is to be given ***treatment, care or support****;*

(b) may be given medication for the treatment or amelioration of the person's mental dysfunction that is prescribed by a doctor; (c) that the person is to undertake a counselling, training, therapeutic or rehabilitation program.

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[5] *Guardianship and Management of Property Act 1991*(ACT).

[6] *Powers of Attorney Act 2005* (ACT).

[7] *Health Attorneys Act* 2008 (ACT).

[8] S 7B (e) and Dictionary (f) *Guardianship and Management of Property Act 1991* (ACT).

[9] A mental illness means a condition that seriously impairs (either temporarily or permanently) the mental functioning of a person and is characterised by the presence in the person of any of the following symptoms: (a) delusions; (b) hallucinations; (c) serious disorder of thought form; (d) a severe disturbance of mood; (e) sustained or repeated irrational behaviour indicating the presence of the symptoms referred to in paragraph (a), (b), (c) or (d).

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

[11] *Mental Health Treatment and Care Act 1994* ACT.

[12] Ibid 36A(1).

9. Section 36G(3)[13] of the *MH Act,* specifically states that a CCO authorises the giving of medication for the treatment or amelioration of the person's mental dysfunction, and the Care Coordinator may—

(a) approve the ***administration*** *by appropriately trained people* ***of medication*** *prescribed by a doctor in accordance with the order; and(b) for that purpose,* ***use*** *(or authorise someone else to use)* ***the force and assistance that is necessary and reasonable*** *and subject the person to the confinement or restraint that is necessary and reasonable—*

(i) to prevent the person from causing harm to himself, herself or someone else.

10. A CCO, as noted above, does not limit or qualify the *treatment, care and support* it can authorise, and so it can be used to consent to non-psychiatric treatment. Accordingly, if a person who is refusing treatment, is deemed to be suffering from a mental dysfunction, a CCO could be made, and appropriate treatment (including that for a physical illness) could be authorised accompanied by reasonable force.[14]

11. On the other hand, under S35(2)[15] of the *MH Act,* a PTO authorises the Chief Psychiatrist to:

(c) subject the person to the ***confinement or restraint*** *that is necessary and reasonable—*

(i) to prevent the person from causing harm to himself, herself or someone else; or

(ii) to ensure that the person remains in custody under the order; and

(d) subject the person to involuntary seclusion if satisfied that it is the only way in the circumstances to prevent the person from causing harm to himself, herself or someone else.

12. Accordingly, if the person is suffering from a *mental illness*, although there are powers under a PTO with regard to detention and restraint, this authorisation to use force only applies to physical confinement, not treatment. For example, a person with

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[13] Ibid 36G(3).

[14] s37(2)(a)(i) Mental Health (Treatment and Care) Act 1994 *"using such force as is necessary and may subject the person to such restraint as is necessary and reasonable".*

[15] Ibid 35(2).

a diagnosis of schizophrenia admitted to the Psychiatric Services Unit suffering a psychotic episode, following assessment is referred to the ACAT for a PTO which authorises involuntary detention and restraint if required, and treatment of his psychiatric condition. If the person is also requiring treatment for a gangrenous ulceration on his leg he will need to have a separate substitute decision maker appointed because he has been assessed as not having the capacity to *consent.*

13. Any of the categories of appointees as detailed above, including the Public Advocate of the ACT (PA ACT) who can be appointed by the ACAT to take on the powers of Emergency Guardian,[16] can give consent if they believe that such treatment is in the person's best interests. However, while any substitute decision maker can consent to treatment even if the person is refusing, none can authorise the use of force or restraint, which could be deemed battery or assault under the right of autonomy.

C. Do other jurisdictions have legislation that can authorise consent to physical treatment and the use of force under a PTO or equivalent?

14. **In NSW,** while there are separate definitions for *mental illness* and *mental disorder in the Mental Health Act 2007,* there is only one category of Community Treatment Order (CTO) that gives directions for treatment in detention and in the community for both mental illness and mental disorder. The *Objects* include to *(a) provide for the care, treatment and control of persons who are mentally ill or mentally disordered, and (b) facilitate the care, treatment and control of those persons through community care facilities.*[17] The legislation **does not qualify *care and treatment* as applying only to *psychiatric* treatment or to excluding psychiatric treatment.** The *Principles*[18] state that people *should receive the best possible care and treatment in the least restrictive manner.* There is no reason not to believe that this covers all treatment for whatever conditions the person is suffering from, including physical.

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[16] *Guardianship and Management of Property Act* 1991 S69.
[17] S3(a) *Mental Health Act 2007.*
[18] Ibid s68.

15. The *affected person* must comply with the CTO and the *director of the mental health facility may take all reasonable steps to have medication administered, and services provided, in accordance with the order.*[19] Again, there is no qualification that this is restricted to *psychiatric* treatment. In addition, *medication may be administered to an affected person for the purposes of a Community Treatment Order without the person's consent* with force, as long as it is no *more force than would be required if the person had consented to its administration.*[20] If a person breaches a CTO by refusing to comply with treatment, they can be returned to a mental health facility where the *authorised medical officer may cause the person to be given treatment in accordance with the community treatment order.*[21] It would be reasonable to conclude that this could include the use of force.

16. In NSW, a CTO can cover treatment for a non-psychiatric condition, and that treatment (including medication) can be administered using all reasonable steps including force.

17. **In South Australia** under the *Mental Health Act 2009*, there is only one definition of *mental illness* – that of *any illness or disorder of the mind.*[22] In addition, Community Treatment Orders, which commence at level 1 while the person is in involuntary detention, authorise *the treatment of a person who has a mental illness, for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition).*[23] This does not exclude treatment for the continuation or deterioration of a physical illness.

18. Further, *[t]reatment centre staff may exercise, in relation to a patient to whom a detention and treatment order applies who is present at, or has been admitted to, the centre, any power (including the power to use reasonable force) that is reasonably required — (a) for carrying the order into effect.*[24] This allows force to be used if necessary in the administration of treatment to a person with a mental illness at a

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[19] S57(2) *Mental Health Act 2007 NSW.*
[20] Ibid s57(3).
[21] Ibid s61(3).
[22] Part 1(3) *Mental Health Act 2009 SA.*
[23] Ibid Part4 Div1 10 (1).
[24] Ibid s34(1).

centre, without qualifying the type of treatment. There is no qualification as to whether this is limited to mechanical restraint only.

19. **In Queensland**, the *Mental Health Act 2000* applies to people with a *mental illness - a condition characterised by a clinically significant disturbance of thought, mood, perception or memory.*[25] The qualification is that *treatment provided must be administered only if it is appropriate to promote and maintain the person's mental health and wellbeing.*[26] Non-psychiatric treatment could be administered if its purpose was for the person's well-being.

20. With regard to the use of force, *[d]espite the absence or refusal of the person's consent, medication may be administered to the person while being taken to the authorised mental health service,*[27] and a practitioner may treat people under a community order or involuntary treatment order, who are refusing treatment, *exercising the power with the help, and using the force, that is reasonable in the circumstances.*[28] Further, under s143, a doctor may authorise the use of mechanical restraint and *reasonable force for detention and treatment.*[29]

21. The Queensland *Guardianship and Administration Act 2000,* allows a *health provider ... to use the minimum force necessary and reasonable to carry out health care authorised*[30] for a person who has been deemed as having a decision making incapacity (which could include a mental illness) under this Act and therefore for whom a Guardian has been appointed. It also applies to **any** treatment administered to such people. The Adult Guardian may also give short term approval for containment or seclusion.[31]

22. **In Victoria**, the *Mental Health Act 1986,* presently under review, includes as Objects to *(a) provide for the care, treatment and protection of mentally ill people; and (ab) facilitate the provision of treatment and care to people with a mental*

[25] S12(1) *Mental Health Act 2000 QLD.*
[26] Ibid s8(h).
[27] Ibid s26 (1).
[28] Ibid s118(5).
[29] Ibid s517.
[30] Part 4 s75 *Guardianship and Administration Act 2000.*
[31] Ibid 80ZH(1).

disorder.[32] The *Act* uses the term *mental disorder* which is not defined except to state that it *includes mental illness* - a *medical condition that is characterised by a significant disturbance of thought, mood, perception or memory*. It defines treatment of a mental disorder, as *things done in the course of the exercise of professional skills to (a) remedy the mental disorder; or (b) lessen its ill effects or the pain and suffering which it causes*.[33] This *Act* specifically includes direction for non-psychiatric treatment, which can be performed without consent if it is minor and is to prevent (b) serious damage to the patient's health; or (c) the patient from suffering ... significant pain or distress.[34] Otherwise *informed consent of the person or of a substitute decision maker must be obtained*, but this can be the authorised *psychiatrist if there is no other person*.[35]

23. The *Act* states that mechanical restraint can be used for a person receiving treatment for a mental disorder in an approved mental health service, (a) if that restraint is necessary (i) for the purpose of the medical treatment of the person.[36] It refers to the use of force in transporting people to a facility, but not use in relation to compulsory treatment.

D. What case law supports the compulsory provision of physical treatment for people with a mental health condition, and are there any cases where the use of force was allowed?

24. In relation to whether "treatment" in Mental Health legislation should be taken to include other than psychiatric treatment, there are several cases of interest.

25. In *Re: Langham*[37] a man with treatment resistant schizophrenia was refusing to eat, and the question was asked whether the provision of artificial nutrition and

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[32] S4(1) *Mental Health Act 1986 Vic.*
[33] S3 *Mental Health Act 1986 Vic.*
[34] Ibid s84(3).
[35] Ibid s854(b).
[36] Ibid s81(1).
[37] *Re: Langham [2005] QSC 127.*

hydration (ANH) was "treatment" under the *Mental Health Act* (QLD). Chesterman J stated:

> *The conduct in question, the fruit of the delusion, is the rejection of food and drink. To supply the first respondent with sustenance, even against his will, is to treat a symptom of his disease. It is therefore treatment as defined by the MH Act: it is done with the intention of alleviating his suffering, which is therapeutic.*[38]

26. Further, while he stated that ANH was both treatment for mental illness and health care, he found that the *MH Act* ousted the *Guardianship Act*, and that 'treatment' should be widely interpreted because it was impossible to distinguish between the deluded thought and the action or consequence which followed: both were considered symptoms of schizophrenia.

27. In *Re: Langham*, His Honour referred favourably to *B v Croydon Health Authority,*[39] an English case in which the young woman, "B" was suffering from a serious mental illness that could only be treated with psychoanalytic psychotherapy, and was refusing to eat. However Hoffman LJ in his judgment stated that:

> *It does not however follow that every act which forms part of that treatment ... must in itself be likely to alleviate or prevent a deterioration of that disorder. Nursing and care concurrent with the core treatment ... are in my view all capable of being ancillary to a treatment calculated to alleviate or prevent a deterioration of the psychopathic disorder.*[40]'

28. Further Chesterman J referred to *MM v Mental Health Review Board,* an unreported case from the Supreme Court of WA, where an elderly woman with dementia appealed against her detention in a care facility, despite not being able to manage independently outside. Scott J in this case stated that while the *Mental Health Act 1996* (WA) did not have a definition of treatment, he considered that it would include 'the provision of "supervision and a safe environment in which to live,"'

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[38] Ibid [19].
[39] *B v Croydon Health Authority* [1995] Fam 133.
[40] Ibid (139).

and that that treatment 'should be interpreted widely in the context of this statute in order not to subvert the intent and purpose of the provision.'[41]

29. The inevitable conclusion is that if the deluded thought and its consequences (or the actions it generates) cannot be distinguished, treatment could be authorised for a wide range of physical conditions under Mental Health legislation without consent. In addition, each of these cases quoted above, involved the use of force in providing the treatment.

30. In *ACT v JT,*[42] *ACT Health* asked the Supreme Court for a Declaration as to whether it was lawful to not administer nutrition and hydration, other than was necessary for the provision of palliative care, for an elderly man who was refusing to eat or drink, and was aggressively resisting all efforts to provide nutrition via a nasogastric tube. JT was suffering from paranoid schizophrenia characterised by religious obsessions and his fasting amounted to starvation and was life threatening.

31. In his judgment, Higgins CJ stated that *it might well be unlawful*[43] (to grant such a declaration), and refused the application. Further he added:

> *[i]t is not a relevant consideration ... that the Territory's relevant care providers would find the provision of care distressing and believe it to violate JT's s10*[44] *rights to humane treatment. They remain under a duty to give competent and effective treatment despite that concern.*[45].

32. In announcing this judgment His Honour was authorising the use of force to provide treatment (which the providers had claimed was a violation of JT's dignity).

33. There is little case law in Australia but considerable overseas cases where medical treatment and care forms part of the treatment for the mental health condition, such as in feeding for patients suffering anorexia nervosa – see *Riverside*

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[41] *MM v Mental Health Review Board*, (CIV 2235 of 1998 judgment given 4 March 1999).
[42] Australian Capital Territory v JT [2009] ACTSC 105.
[43] Ibid [66].
[44] *Human Rights Act 2005* ACT.
[45] *ACT v JT* [63].

Health NHS Trust v Fox,[46] where the Judge observed:

> "until there is steady weight gain no other treatment can be offered for the respondent's mental condition so I hold that forced feeding if needed will be medical treatment for the mental disorder".

In *Reid* v *Secretary of State for Scotland*[47] the decision was that:

> 'the treatment ought to be given having regard to the likelihood that it will alleviate or prevent deterioration in the patient's condition.'

34. This has sometimes been quoted as authorising only physical treatment that is directly related to the person's mental illness, whereas some of the above cases refer to the impossibility of differentiating between the two – with the rejection of the physical treatment being the fruit of the delusion.[48]

35. Fennell[49] (2007) moves the discussion into the realm of "incapacity" rather than mental illness or dysfunction. He refers to it as the *The Convergence Agenda.* In this he states that *"decisions to treat without consent should be based on the same criterion, mental incapacity, regardless of whether the treatment is for mental or physical disorder"*, and he quotes a number of English cases in support of this.[50]

36. This takes the discussion into the involuntary treatment for persons with incapacity who are refusing that treatment. In Australia, Queensland has legislation that gives authority to the medical practitioner to use force or restraint if required in providing treatment for a medical condition in such circumstances. The person must be assessed as having a decision making incapacity, and a substitute decision maker must be appointed. If that substitute decision maker gives consent to the proposed treatment, after discussion with the medical practitioner and believing that

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[46] *Riverside Health NHS Trust v Fox* [1994] 1 FLR 614-622.

[47] *Reid* v *Secretary of State for Scotland* [1999] 1 All ER 481.

[48] *Re: Langham [2005] QSC 127*

[49] Phil Fennell *Best Interests and Treatment for Mental Disorder*. Cardiff Law School. Cardiff 12 April 2007

[50] *R (PS)* v *RMO, Dr G (1) SOAD, Dr W (2)* [2003] EWHC 2335 (Admin), *R (B)* v *Dr SS (1) Dr AC (2) Secretary of State for Health* [2005] EWHC 86 (Admin), *R (B)* v *Dr Haddock* [2005] EWHC 921, [2005] EWCA Civ 1726 *R (B)* v *SS, RMO, Broadmoor Hospital and others* [2005] EWHC 1936 (Admin) [2006] EWCA Civ 28

it is in the person's best interests, the medical practitioner can use the force necessary, within strict guidelines, to administer that treatment. This would be best implemented by introducing such an authority into the Health Act.

E. Conclusion

37. The ACT is out of step with legislation in other Australian jurisdictions, and internationally, by having a different Compulsory Treatment Order for mental illness (PTO) and mental dysfunction (CCO). In addition, a PTO limits treatment to *psychiatric* only. Not only is this inconsistent with other jurisdictions, it could be seen as discriminatory because a person under a PTO cannot be treated involuntarily for a physical condition, but there are no limitations regarding treatment under a CCO.

38. Statute in most States provides support for this common law principle by not limiting the definition of treatment to *psychiatric*, or by being silent on the matter. In addition, case law supports the proposition that in some circumstances treatment of physical symptoms can be classified as *treatment for mental health,* and substitute consent can be given where the person is under an involuntary order.

39. In regard to the use of force, the *MH Act* only provides for the Chief Psychiatrist to authorise confinement or restraint, not to administer treatment to a person under a PTO, whereas under a CCO, the Care Co-ordinator can approve the use of force that is necessary and reasonable in the administration of medication.

40. Case law referred to above has supported the use of force where necessary to treat a person. Most examples of this are in relation to physical treatment, because it is practice that a person with a mental illness can be involuntarily confined and then force, or coercion, is used to provide the treatment required.[51] This is outside the Mental Health legislation, in that it relates to all persons with an cognitive incapacity.

[51] In many overseas jurisdictions, notably the Netherlands, while people are compulsorily confined, if they are at risk to themselves or others, they are not compulsorily treated, but counselled and persuaded to agree to treatment over time.

The introduction of such legislation would remove the current dubious practice of placing persons under a CCO in order to use coercion or restraint to provide treatment. Such legislative amendment would not give additional powers to the substitute decision maker, but to the medical practitioner who is responsible for the administration of the treatment.

F. Recommendations

(i) The Review of *the Mental Health (Treatment and Care) Act 1994*, bring that Act in line with other jurisdictions, by creating **one Order for the compulsory treatment of all mental health conditions.**

(ii) This **Order should authorise the treatment of any condition** for which the person is suffering, not limiting or qualifying the treatment, care and support it can authorise.

(iii) This generic **Order should allow the use of force or coercion** in regard to the administration of treatment where this is necessary, and controlled by strict standards of operation compatible with the *Human Rights Act.*

(iv) The ACT *Health Act* should be amended to **allow health practitioners to use restraint or coercion in administering treatment** to a person who has been assessed as lacking decision making capacity and who is refusing that treatment once an authorised substitute decision maker has consented in writing to that treatment.

Anita Phillips
ACT Public Advocate
29 August 2011

Review of the ACT Mental Health Act
Review Advisory Committee

AGENDA
Friday 30 September 2011
Conference Room, 3rd Floor 11 Moore Street
9:00 – 10:30am

No	Item	Responsibility
1	Welcome	Ross O'Donoughue
2	Apologies	
3	Involuntary Physical Care Update	
4	Updates/Feedback from Working Groups, advice and suggestions from RAC : Forensic Mental Health Other Working Groups	 Victor Martin Steve Druitt
5	Future meeting dates and times	Ross O'Donoughue

Review of the ACT Mental Health Act Review Advisory Committee

AGENDA

Friday 14 October 2011
Conference Room, Level 3, 1 Moore Street
9:30 – 11:00am

No	Item	Responsibility
1	Welcome	Ross O'Donoughue
2	Apologies	
3	Update of Working Group Recommendations with feedback from Policy management Team RAC comments	Steve Druitt
4	Future meeting dates and times	Ross O'Donoughue

Mental Health Act Review: Review Advisory Committee Notes: 14 October 2011

Attendees:

Steve Druitt: Mental Health Policy Unit

Rosemary Kenna: Mental Health Policy Unit

Dalane Drexer: ACTMH Consumer Network

Linda Crebbin: ACAT

Sgt Greg Booth: AFP Community Policing Initiative

Const. Jess Brenner: AFP Community Policing Initiative

Matt Hingston: Human Rights Commission

Renate Moore: CMD

Sue Watson: Disability ACT

Austin Kenney: Disability ACT

David Lovegrove: ACTMH Consumer Network

Trish Mackay: Principal Advocate

Dr Peter Norrie: Chief Psychiatrist and Director of Clinical Services

Sean Costello: Human Rights Commission

Bill Kerley: Carers ACT

Victor Martin: JACSD

Ross O'Donoughue: ED, Health Policy and Government Relations

Application for an involuntary order, and documentation of basis of decision

Discussion around RAC providing the Tribunal with a form detailing the necessary steps required when an Order issued for a person. Tribunal president clarified that under the relevant legislation, the Tribunal was responsible for determining the forms that would be used for Tribunal processes.

Tribunal is aware that a new form would be required and is prepared to liaise regarding its content with interested parties, however reiterated that the Tribunal needs to maintain its impartiality. Tribunal is very interested to ensure that there is clear information to show the impact of the change.

Review period

Discussion of timing of the review of change to criteria - Linda Crebbin suggested that it would be better to set a goal of reviewing the data every 12 months – as the impact of the change and need to respond may become quite evident early. Agreed to enshrine timing in legislation.

'Bournewood' Recommendations

Ss 69, 70 of the Guardianship Act allows for consent to be given for prescribed medical procedures, (eg) contraception.

Suggestion that a similar provision be made for a person with mental illness /dysfunction, who is compliant but lacking capacity. Thought that the Guardianship and Management of Property Act (GMPA) would need to be amended as the current provisions only operated where there was guardianship order and the incapacity was enduring. Also concern that guardianship may need reviewing more frequently than 3 yearly in these cases.

Ms Crebbin advised that review can and does occur more frequently eg every 3 or 6 months. Tribunal President stated that s 69 of the Guardianship Act not confined in application to only those with enduring incapacity. Example given of man with paraphilia for whom the mental illness was not enduring, but nonetheless that provision has been applied.

Tribunal President stated that s 70 authorises a prescribed medical procedure, consequent upon a determination of incapacity. In cases where the issue referred to contraception, the practice was to often to order a review at 12 months.

Tribunal President referred to current review of guardianship occurring in Victoria by Neil Reese, which had focussed on Bournewood issue; possibility that he could give a presentation or advice about his views to RAC. **RAC will await outcome of Ms Crebbins inquiry.**

Statement about importance of legal oversight and control mechanism regarding decision to place someone on an order. Necessary to carefully oversee the decisions of a guardian to agree to psychiatric treatment for the person cared for. Regulation mechanism demands consideration

When young people can decide their treatment

Recommendation that the Gillick principle and decisions flowing from that be enshrined in legislation, which would have educative value eg in the event of a dispute with parents –the principle could be referred to for guidance.

Policy Management Committee had requested at their last meeting that the **views of the Childrens' and Young Peoples Commissioner and Health Services be sought** on the inclusion of the principle.

ECT for those less than 18 years

Notwithstanding the rarity of the need for the procedure on juveniles, it was felt that there needed to be retained a provision in the Act whereby ECT on a person under 18 years should be allowable, with the assurance that there were safeguards to ensure procedure was only allowable if certain conditions were met.

Discussion around the issue of broadness of "under 18" term; there was a provision in equivalent Victorian Act which specifically banned the use of ECT for children under 12; similarly in Western Australia where it **was banned for children under the age of 12.** Information from these two jurisdictions was to be forwarded to Steve Druitt by David Lovegrove.

Broadly supported that for older two consultants should recommend on ECT, and that the decision should be made by Tribunal. This was stated as the current arrangement in Victoria.

One objection that there should be a ban on ECT for all under the age of 18, as was stated to be the case for involuntary ECT in Ireland. Counter argument that if this were the case, then if treatment was required to save life and the person was under 18, catastrophic consequences could ensue if that person was prevented from receiving an ECT under such a provision.

The view was expressed with broad agreement that in a case where consent to treatment was required for an under 18 year old, then the parents should not be the decision makers- that the Tribunal should decide the issue.

Consumer representative suggested that ECT should only be last resort treatment after all other possible treatments have been trialled; that detailed evidence should be documented of other options attempted prior to consideration of ECT. I\Point was made that ECT was considered the option of last resort in general, and in particular for young people

Chair summarised that there was general agreement that controls around ECT for young people should be tightened.

The consumer representative highlighted the importance of the psychosocial factors that impacted on the person's mental health and that often these issues were substantially implicated in a person's deterioration and their eventual requirement

for ECT. Concern that there should be ongoing consideration of the significance of addressing these drivers to mental ill health.

Information forwarded to **Child and Young Person working Group and awaits a recommendation from them**

Accommodation of acutely ill forensic young people

General consensus that this issue should be dealt with through operational policy

Principles and Objectives of the Act

Decision making capacity to be put into principles.

Aboriginal and Torres Strait Islander People

The intention was stated to have a principle in the Act whereby any decision under the Act which impacted on Aboriginal or Torres Strait Islander peoples should acknowledge the necessity of the decision maker possessing cultural competence in relation to the particular needs and characteristics of those who identify with ATSI culture.

Technical Matters

The current position was supported of a second Emergency Detention of 11 days, lapsing to 7 if not supported by a second consultant review within 7 days. Review of this provision in 18 months from enactment, this to be enshrined in legislation.

Provision of health information to Carer by Record Keeper

General support for strengthening the provision that carers be provided with sufficient information about the health of the relevant consumer (balanced by the importance of privacy considerations for consumer).

Statement that the proposition that these two aims were mutually exclusive was false- sufficient information necessary for carers to be properly able to care for consumers could be provided without compromising consumers' privacy rights.

Suggestion that Advance Agreements could usefully include consumer wishes in regard to release of personal health information.

Statement that it should be remembered that at duty of care in regard to a consumer overrode privacy considerations.

Time limit for police involvement in conveying a consumer to a treatment centre

Proposition that the 90 minutes for police to take a person to a place for treatment should start from the point in time where the person was in police custody en route to treatment.

Debate around the 90 minutes being a defined time limit, a guide, or whether the provision should specify that the time was to be 90 minutes "unless exceptional circumstances exist."

Suggestion that the purpose of imposing a time limit was to guard against the person being in indefinite detention, or detention that was unregulated- a statement at a principle level was enough to guard against the person being detained for an unreasonably lengthy time. Point was made that other jurisdictions are silent on a specific time limit being imposed. The main area of concern was more around regulating time the consumer spent in hospital rather than the time spent to get to a place of treatment.

Police position stated as opposed to imposing a time limit on the process because there would be pressure placed to comply with the requirement in situations where this might exacerbate resistance to police involvement by a consumer.

Argument that imposing a time limit would mean that unforseen contingencies such as an accident or other incident could not be accommodated and there was no point in time specification in the legislation.

Discussion around whether police were necessarily the most suited to perform this function; that ambulance officers or mental health personnel may be better suited to transport a person to detention. View was stated that police should be used only where there was threat of violence.

Involuntary physical care

Current provisions meet the need for a person lacking capacity who is compliant – Health Attorney, guardian, EPA, could be included in Advance Agreements

Supported recommendation that If person lacking capacity is resisting treatment, the public guardian to be appointed to authorise treatment, AA taken into account

Advance Agreements (AAs)

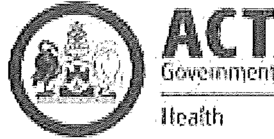
Should where possible identify physician and notify of existence of physical health provisions in AA

ACT MH Act Review – List of recommendations 14 October 2011		
WG	**RAC to consider**	**Recommendation**
DMC		Format for application and decision on order that will ensure decision making capacity is reported and provide data for a review
	#	Review of criteria in 3 years
	#	For Bournewood clients, a provision under or similar to S69 &70 of GMPA (consent to prescribed medical procedures) Modifications needed: allow psychiatric treatment, no requirement for guardianship order, any duration of incapacity) Alternative: Provisions similar to those for Involuntary Physical Care (see below)
CYP		Enshrine Gillick Principle
	#	ECT under 18years (?two opinions, Tribunal decision)
		Accommodate acutely mentally ill young people in a health facility as far as possible
P&O		Version seen by RAC has some later modifications regarding decision making and rights – will circulate and explain changes at meeting)
Technical	#	Extend length of second Emergency Detention to 11 days, (*?lapsing to 7 days if not supported by second review by consultant within 7 days*). Review of this provision in 18 months (*3 years?)* from enactment, enshrined in legislation
	#	Encourage more use of short term orders
	#	Retain existing scheme for length of orders
		(Health Records Act) Record keeper should provide information to the carer to enable safe and effective care unless there is compelling reason not to, balanced with consumer need for privacy
		(Health Records Act) Record keeper should share information with other agencies to enable safe and effective care unless there is compelling reason not to, balanced with consumer need for privacy
		21 other recommendations not controversial agreed
IPC	#	Existing powers enable consent by Health Attorney, Power of Attorney or appointed guardian if the

		person is compliant but lacking capacity If the person is resisting treatment, Tribunal appoints a public guardian who can authorise treatment. The Tribunal can empower the Health Service to use minimum necessary force to give treatment
AA	# partial	Advance Agreements are recognised and to be followed unless a Consultant advises that they need to be overridden, in which case an application is made to the Tribunal. Can be altered by negotiation if the person has capacity. An order of the Tribunal suspends specific provisions of the AA for an agreed period
Forensic	#	To be advised at 21 October meeting

Key

WG	Working Group
DMC	Decision Making Capacity
CYP	Children and Young People
P&O	Principles and Objectives
IPC	Involuntary Physical Care
AA	Advance Agreements



Review of the ACT Mental Health Act Review Advisory Committee

AGENDA

Friday 21 October 2011
Conference Room, Level 3, 1 Moore Street
9:30 – 11:00am

No	Item	Responsibility
1	Welcome	Steve Druitt
2	Apologies	
3	Update of 'Bournewood' provisions in light of advice from Victorian review of Guardianship	Steve Druitt
4	Forensic provsions	Victor Martin
4	Future meeting dates and times	Steve Druitt

RAC MEETING NOTES 21 OCT 2011

Attendees:

Steve Druitt: Mental Health Policy Unit

Rosemary Kenna: Mental Health Policy Unit

Dalane Drexer: ACTMHCN

SGT Greg Booth: ACT Mental Health Community Policing Initiative

Const Jess Brenner: ACT Mental Health Community Policing Initiative

Matt Hingston: HRC

Renate Moore: CMD

Austin Kenney: CSD

David Lovegrove: ACTMHCN

Trish Mackay: Principal Advocate

Victor Martin: ACTJACS

Denise Caldwell: Pubic Advocate's Office

Simon Viereck: MHCC

Apologies

Bill Kerley: Defence

Ross O' Donoghue: ACT Health

Vera Van Dyke:

Sue Watson: Disability

Christina Ryan: Advocacy for Inclusion

Linda Crebbin: ACAT

David C

Involuntary physical care

(GMPA - Guardianshp and Management of Property Act)

Reiteration re the following:

Since the MH Act does not authorise involuntary physical care for people suffering a mental illness that:

There be a consequential provision in the ACT Guardianship and Management of Property Act 1991, whereby, when a person with a mental illness who lacks decision making capacity regarding their physical treatment, resists physical treatment which could result in a risk to life, or risk of serious deterioration in physical or mental health; or risk of continuing serious impairment of physical or mental health, the ACAT can confer power to the Public Guardian to authorise such treatment.

That further, the Tribunal can separately authorise a health service to use such minimum force as is necessary to effect the authorised treatment (ACT Health Act).

HRC was concerned that the process be commenced by an application to the ACAT in the first instance. ACAT would consider whether to confer power to the Public Guardian (PG) to authorise a treatment decision on an involuntary patient re physical care. Tribunal would then, if appropriate, authorise the treatment, separately authorising a Health Service Provider to employ such minimum force as was necessary to effect the treatment.

HRC also concerned to ensure that if the PG was already empowered to make decisions regarding a person and that person subsequently needed physical care to which they did not consent, there would need to be an application to the ACAT as per above process at such a point, to determine the PGs authority to decide regarding this new issue.

HRC concerned to ensure a heightened level of oversight and protection for consumers potentially subject to decisions as described above.

(Human Rights Commission also expressed concern following the meeting that the implied right of the Public Guardian to approve enforceable treatment was such a departure from the current provisions of the GMPA as to require public consultation or possibly a broader review of the GMPA.)

Forensic Issues

Paper presented by JACS detailing forensic provisions proposed for amended MH Act.

JACS stated that one of the key overarching principles to be borne in mind in relation to the issue of forensic mental illness was the consideration of public safety. This needed to be borne in mind at the same time as acknowledging the rights of forensic mental health consumers as expressed in Rights instruments referred to in JACS paper.

Forensic Objects and Principles

Diversion

Issue of community safety important to be borne in mind when diversion considered.- this to be considered by the ACAT when considering a matter relating to a forensic patient.

MH Policy had suggested that it was important to clarify that the risk to the community under consideration was to be a **serious** risk to the community. This would ensure that orders were only made where appropriate.

Discussion of the objects applying to forensic provisions.

Concerns were raised by a number of participants regarding the object of the forensic provisions:

2.1 (c) to facilitate the care treatment and support of any of those **persons in a corrections centre or youth detention facility** through treatment orders.

Concerns raised were around the fact that enshrining this wording in legislation sent a message to the community that the treatment of mentally ill persons in a detention environment was acceptable, and would therefore be perpetuated, whereas the ideal place for care of a mentally ill person was in a dedicated therapeutic environment.

JACS accepted the concern but stated the provision reflected the reality that there was no treatment specific facility for mentally ill forensic consumers, even though this may be the optimum environment for the treatment of such individuals.

JACS made point made that even if a mentally ill person to be treated in a mental health specific environment, (for example by transfer under s 309 Crimes Act: the person to be transferred from custody to the PSU) such a person, unless they are low security, may be required to be accompanied by custodial officers in the therapeutic environment.

Action *Agreement to discuss Objects and Principles 2.1 (c) in forthcoming Policy Management Meeting re above concerns.

Limiting Term

Discussion around the various options in regard to the limiting term; that there should be no limiting term, that there be acceptance of principle that detention was a last resort in case of young person but that this should not be used to override therapeutic aims.

Proposal for new Forensic Orders

Discussion regarding definition of **seriousness;** suggestion that there should not be prescription in the legislation regarding seriousness; this would allow the ACAT to decide flexibly on the issue.

Action * Agreement to discuss the issue of seriousness and how it might be determined at Policy Management Meeting

Length of orders

JACS stated that orders would be of 12 months duration, that such a period would be sufficient to allow for appropriate treatment for the person subject to order. Opinion that the "least intrusive" consideration does not apply in the same way in the forensic context as in the civil.

HRC suggests that 12 months is a long period of time for a person to be subjected to an order without a Review. Suggestion made that the order period *might be reduced for children and young people to 6 months.*

Rights for affected persons

JACS stated that affected persons provisions apply only to forensic provisions. Clarification that the affected person is defined for these purposes as per the affected person definition in the Victims of Crimes Act.

When an affected person appears before ACAT the Victims of Crime Commissioner will have a right of appearance.

Search Provisions

AFP raised issue of mental health workers being empowered to conduct search of consumer. AFP keen to have police involvement minimised in the scenario to avoid stigma .

AFP acknowledged that if the person being searched refused to cooperate then police would need to be called. It ws commented that positions being supported were the same

Action *Agreement that this issue requires further deliberation at Policy Management Meeting.

Carers' right to information regarding consumers

MH Policy stated that there had been discussion with HRC re Carers' right to receive information. HRC was concerned that legislating for carers' right to information would ossify the principle and potentially cause difficulties in the long term. HRC proposed that the best

way to avoid potential difficulties whilst acknowledging the importance of carers in some situations to have access to information to care adequately for a relevant consumer, was to promote the principle at a policy level.

Gillick Principle

MH Policy related HRC analogous concerns re legislating for Gillick principle; best route was suggested as not via legislation, because this might cause potential difficulties long term, but to promote the principle through policy, procedures, guidelines.

Future paper

MH Policy also suggested that a paper be prepared to tabulate those issues that despite their significance, have not been considered best addressed by legislation. This would keep the issues alive and enable further discussion around the best way to address them. Agreed

Review of the ACT Mental Health Act
Review Advisory Committee

AGENDA

Friday 2 November 2012
Conference Room, Level 3, 1 Moore Street
9:30 – 11:00am

No	Item	Responsibility
1	Welcome, Introductions and Terms of Reference	Ross O'Donoughue
2	Apologies	Ross O'Donoughue
3	Feedback from First Exposure Draft and discussion of recommendations for change	Ross O'Donoughue, Victor Martin and all
4	Future meeting dates and times	Ross

Review of ACT Mental Health Act 1994

Chair's Notes – Review Advisory Committee Meeting 2 Nov 2012

Conference Room, Level 3, 11 Moore Street

- The feedback is in two parts (Health and JaCS administered sections) It may be better to address JaCS (forensic, VOCC etc) to make sure we get to it
- Both are divided into 'significant change' at start and 'minor change'. You could invite discussion on the significant changes, and ask people to email comments or raise them only if they need discussion
- Authors of feedback have not been identified at your suggestion
- The recommendations only include about half the submissions at the moment, although of course there is significant overlap. I have noted where there has been a lot of similar feedback.
- The submissions included are: results of public meetings, most private submissions, Carers ACT (although many of their recommendations have been held back pending the outcome of a Carers Working Group currently operating), Advocacy for Inclusion, Legal Aid, ACT Policing, and Victims of Crime Commissioner
- Submissions not yet included (although there I is significant overlap) are: ACTCOSS, MH Community Coalition, MH Consumer Network, Human Rights Commission, Public Advocate. These have been summarised but there is a fair bit of editing to finish.
- There is a lot of discussion about further development of decision making capacity, to some extent beyond the point agreed by RAC. This is influenced by Article 12 of the Convention on the Rights of People with Disability, and the current developments around supported decision making. Interpretation of Article 12 is on a spectrum up to there can be no future involuntary treatment. The Human Rights Commission states in their submission that in Australia the consensus is coming down in favor of a continuing need for involuntary treatment. There is a range of views in ACT but none seem to completely support no more involuntary treatment. We have suggested supporting some of the recommendations made in this area.
- There are ongoing concerns around the protection under Guardianship around compliant non-capacitous people, if they are treated under the GMPA. The Human Rights Commission has recommended a full review of

GMPA in their submission, with a focus on provisions for this group,. This may answer the need

- Richard suggested a next RAC in one week, to give people time to deliberate, and also see the rest of the feedback. The timetable says we are to get finalized changes to PCO in early November so we are pushing it. Then Second Exposure early 2013, and final to LA end of 2013. (So some internal flex in timetable)

MINUTES OF THE ACT MENTAL HEALTH (TREATMENT AND CARE) ACT (1994) REVIEW ADVISORY COMMITTEE MEETING 2/11/12

MEETING MINUTES

Date: **Friday 2 November 2012**
Time: **9.30am- 11.30am**
Venue: **Level 3 Conference Room, 11 Moore St**

1. Welcome, attendance and apologies	Ross O'Donoughue welcomed the group and acknowledged the Traditional Owners.
Ross O'Donoughue	Executive Director Policy Division ACT Health (Chair)
Jon Wood	ACT Ambulance Service
Simon Viereck	Mental Health Community Coalition
Anita Phillips	Public Advocate ACT
Daniel Panozzo	ACT Health Directorate (for Vera Van De Velde)
Doris Kordes	Carers ACT
Dalane Drexler	CEO, ACT Mental Health Consumer Network
Megan Sparke	JACS
Victor Martin	JACS
Sean Costello	Human Rights Commission
Catherine Gough	AFP
Sgt Greg Booth	AFP
Zoe Pope	ACT Health Directorate (for Christine Waller)
Denise Caldwell	Public Advocate ACT
Julia Bocking	Consumer Consultant MHJHADS
Sue Watson	Community Services Directorate (Disability)
Rosemary Kenna	Mental Health Policy and Planning Unit, ACT Health (Secretariat)

Apologies	
Tina Bracher	ED, MHJHADS
Steve Druitt	Project Manager Review Mental Health Act (1994) ACT Health Directorate
Richard Bromhead	Manager Mental Health Policy and Planning Unit, ACT Health
Tony Malone	ACT Corrective Services
Christine Waller	Older Persons Mental Health Services ACT Health Directorate
Dee McGrath	CEO Carers ACT
Mary Durkin	Disability and Community Services Commissioner
Maree Mannion	Community Services Directorate (Organizational Services)
Matt Hingston	Human Rights Commission
Kate Starick	Community Services Directorate(Disability ACT)
Ian Rentsch	Executive Officer, Mental Health Community Coalition
Louise Smith	
Hugh Jorgensen	JACS

Feedback from First Exposure Draft and discussion of recommendations for change

FORENSIC PROVISIONS (PREPARED BY JACS)

Recommendation from a submission (Recommendations)

- **Power should be given to police to arrest, without a warrant, a person in breach of their forensic mental health order.**

Comments at RAC Meeting (Comments)

- Current process of detaining a person under an Emergency Action if :(a)there is risk of suicide or: (b) risk of harm to others is cumbersome
- If the person does not meet either (a) or (b) there is no power of arrest
- In a Forensic context there is a higher degree of risk if no power to arrest; person could not be brought back to a facility

- Warrant provision may not be the way to address this
- A breach of order process, similar to a Bail breach may be the sort of process required

Recommendations

- **Search powers should be extended for police when exercising their power of arrest**

Comments

- Police do not have a power of arrest under the Mental Health Act
- Police are not seeking a strip search power but a power to frisk or if necessary do an ordinary search (remove outer items of clothing)
- Police should not be called just to search
- Police seeking something similar to the NSW position re this issue

HRC would appreciate further input into this.

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Recommendations

Section 73(3)(a) and (c)

- **Only those charged or convicted of a criminal offence should be subject to a forensic mental health order.**

Comments

- It is hoped that early intervention to address a person's mental health issues prevents their involvement in the criminal justice system
- The issue is what is the tipping point to call in a forensic order
- Under a forensic order we are not considering capacity as we do in the civil space
- Key goal is to ensure forensic Mental Health Orders are an appropriate option

for a person in the circumstances

- We need to determine what criteria need to be met to trigger a Forensic Mental Health Order

HRC would appreciate further consultation on this issue.

Recommendations

Section 94

- **Section 94 should note the existing jurisdiction of oversight bodies where legislation provides a right to obtain information. For example, the Health Services Commissioner when considering a complaint from relevant person.**

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Comments

- This recommendation is uncontroversial and supported

Recommendations

***Crimes Act 1900*, section 301(3) to (5)**

- **More guidance is required in relation to balancing the provision for the treatment and care of the mentally ill or mentally dysfunctional, and the protection of the community from harm.**

Comments

- This relates to where a person is not acquitted and there is also no finding of guilt and the Court refers the person for a Forensic Mental Health Order (FMHO)
- Court should consider period of time in detention
- Even though it is suggested that at the end of a limiting term where concerns re a patient persist, and criteria are met, a CCO or PTO can be issued, Police are

concerned that these will not go far enough

- It is not desirable that the limiting term results in a person being released and none of their mental health issues have been sufficiently addressed to prevent risk
- Forensic Mental Health Orders will result in greater oversight by ACAT, which despite greater bureaucracy is seen as appropriate to safeguard the interests of the individual and the safety of the community
- ACAT is responsible for oversight as long as the limiting term persists
- If a person is exiting custody after a limiting term, there should be a risk assessment especially if the term has been short and the person is treatment resistant
- See the Victorian system re this issue; Supreme court decides and criteria are onerous

Recommendations

Capacity, section 9

- **There are concerns that a decision as to a person's incapacity to make treatment decisions for MH Bill # purposes might be used to establish a person as not fit to stand trial. Given this risk, legislation needs to be clearer in its definition of capacity**

Comments

- Concerns are that # may be used as a catch all to avoid prosecution
- There is no proposal to change how the mental impairment test operates in the Criminal Code. The "McNaughton rules" are best practice and an appropriate way of diverting people from the criminal justice system where this is appropriate
- The issue of when fitness to plead is assessed is not clear
- Police would like to see an assessment re fitness to plead, to ensure an assessment made as to a person's lack of fitness to plead is not applied globally so as to avoid prosecution.
- JACs believe that legislative fine tuning will not impact this issue
- In order to ensure a fitness to plead assessment occurs on each occasion,

explanatory material for the Bill will be required.

Recommendations

- **Affected people: S 105**
- **An obligation to inform affected people about the existence of the affected people register should be included in the Act. This should clarify how a person is informed of the register and how they register.**

Comments

- Agreement ; HD supports

Recommendations

Section 106(2)

- **There should be specific criteria for assessing whether the Director General should disclose information about a forensic mental health patient to an "affected person" to ensure their safety and wellbeing,**
- **The current wording of section 106 (2) places an obligation on the affected person to justify why they should receive information in relation to the forensic mental health patient. The provision has the potential to be interpreted inconsistently**

Comments

- Information should not be so accessible as to infringe a right to privacy; Access to information should not be made so onerous as to infringe on a right to that information
- The provision suggested is currently possible as the Bill stands but it should be specifically noted in the Bill

Recommendations
• **Remove or further prescribe the ACAT's power to exclude victims from hearings in relation to a forensic mental health client**
Comments • ACAT has power to allow attendance of affected person but this is rarely exercised • It is not desirable to prescribe the functions of ACAT; there is a provision for VOCC to attend • Police must inform victims under the Victims of Crime Act of an issue affecting their safety • Police are concerned that the Bill excludes police from providing information; how will police meet their obligations under VOC Act • JACS states that where police obligations end ACAT assumes obligations around the issue. • Police suggest the ACAT will require a VOC Office
Recommendations **Section 103** **The definition of an 'Affected person' is not appropriate; a more appropriate definition of affected person would be the definition of victim as defined in the *Victims of Crime Act 1994*.**
Comments • A broader definition is suggested to encompass family members under an opt in arrangement • Few people opt in • Need to consider the issue of a young person not wanting information to be disclosed • There is no prescription regarding what info ACAT must provide • JACS: community safety issues should not intrude on a right to privacy

• Police are concerned to ensure a victim receives adequate information to satisfy concerns for their own safety
<u>**Recommendations**</u> **The definition of affected person should also include other people who hold concerns for their safety and wellbeing, such as the definition of 'relevant victim' under s 133(6) (b) of the *Crimes (Sentence Administration) Act 2005*. There should be specific provisions for children who are affected persons.**
<u>Comments</u> • Agree
<u>**Recommendations**</u> <u>**Carers**</u> <u>**S 78 and S 79(d)**</u> • **Section 78 fails to mention primary carer** • **Section 79(d) is unclear; provision states that ACAT must take into account views and wishes of people responsible for day to day care of the person to extent these are made known to ACAT. The provision could mean paid carers; if intention is to refer to unpaid carers this needs to be explicitly stated. Provision places onus on carers to inform ACAT; this should be reversed so obligation on ACAT to enquire.** • **Provision should explicitly refer to carers, even though carer could be encompassed by the categories referred to by the provision. This would ensure access to widest possible breadth of views to assist ACAT decision making.** • **Bill should clearly define carers (unpaid family or primary carers) in the Act, to ensure that carers are adequately included in determinations of forensic mental health orders by ACAT, including the addition of a direct**

reference to unpaid carers in s 78.

<u>Comments</u>

- It is appreciated that where a forensic mental health patient is concerned a carer may be the lynch pin re preserving community safety the carer should have information around a person being prevented from approaching another person.
- We need to look at the Civil provisions and see how these compare

<u>Following is from Part One of Recommendations from Submissions received</u>

<u>S 9M #</u>

<u>Issues</u>

- **Currently there is no provision to formally advise MH services when ACAT, in the process of considering an application for assessment or order, have become concerned of increased risk to the person or others.**

<u>Recommendations</u>

- **That the following provision be adopted in Bill:**
  When the ACAT
  a) is told by the applicant for an assessment order; or
  b) becomes concerned in the process of considering an application for assessment or order
  of a significant level of:
  i) risk to the subject person's health or safety; or
  ii) risk of serious harm to others
  then the ACAT must as soon as possible, in writing, advise the Chief Psychiatrist of the risk

<u>Comments</u>

- Lack of certainty around need for this provision

Issues • **Where the ACAT becomes aware that there is sufficient reasonable concern about risk to the person or others, including risk raised by issuing an assessment order, there is a need to minimise delay in assessment.** **Recommendations** • **Where the ACAT considers that the concern in # above is of sufficient level, they may make an order for assessment without notice, and require that the person be apprehended as soon as possible and taken to an approved mental health facility for assessment.**
Comments • There is already such an apprehension power • Suggestion that police attend in plain clothes and in an unmarked car • This would be an issue to detail re policy and practice, not through legislation • Police see this as not practical as a requirement, though agree that agencies other than police should be involved in this sort of situation • Ambulance Service does not apprehend; staff are not trained to do so and apprehension is not within officers scope of practice
S 53 G **Issues** • **Ending an Advance Agreement: Consumer advocacy that consumers do not want to be able to withdraw their advance agreement when unwell and lacking capacity, as it would 'defeat the purpose'** • **Advice that this does not at any rate correspond to a right to withdraw consent in the broader health environment** • **(several stakeholders supported this change)** **Recommendations** • **Provide that a person may only end an Advance Agreement when they have decision making capacity**

• **The RAC to advise on whether, if the person resists treatment according to the AA, the treating team needs to apply for an Order so as to provide the treatment in the AA.** **"The meeting confirmed that this had been previously agreed in principle by RAC".**
Comments • **There was support for the need for an order where the treating team seeks to give effect to the AA against the person's wishes. The treating team would need to seek an order where they wish to vary an AA.**
S37 (1) **Recommendations** • **Provide for Ambulance Paramedics to apprehend on the basis of assessment of medical risks. (They could ask for mental health assessment where needed)** • **Indicate a 'hierarchy' of responders in emergencies – process?** • **Provide for Ambulance Paramedics to apprehend under Section 37(2) instead of 37(1)**
Comments • Ambulance Service does not support ambulance officers (AOs) physically restraining patients; this is not their function. • AOs can use chemical restraint, but only when safe and as last resort • AOs withdraw if unsafe • Ambulance Service would not support training of AOs to physically restrain; this would apply across the Service; there would be no "specialist squad" for extreme situations; such an arrangement would be impractical given how crews are allocated currently. • Police are concerned there is no legislative basis for chemical restraint; suggestion the power is covered under the Emergencies Act whereby police

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are following the reasonable direction of an AO to assist.

- Under the Emergencies Act the Chief Officer determines AOs scope of practice, including use of pharmacological agents for restraint purposes; but JACS view that the proposed amendments re apprehension in this submission do not contradict the provision referred to regarding the Chief Officer

<u>SUBMISSION G</u>

<u>Issues</u>

- **To enable longer term orders for where a person has a history of repeated relapse when taken off an order. Longer order will allow that they remain in treatment.**

<u>Recommendations</u>

- **Create a classification of 'Chronic mental illness' (or dysfunction) (This recommendation and the one below came from a submission by a carer, see attached)**
- **Extend the maximum length of an Order to 2 years where a person is classified as having a chronic mental illness or dysfunction**
- **allow for <u>review of this two year order at any time</u> to be initiated by the person concerned and /or their legal advisor and /or advocate and /or by MH ACT and/ or the administrators of the Order.**
- **Provision be made to respond to vexatious applications for review of this order**

<u>Comments</u>

- There was not support for a 2 year Order; such a provision would potentially be contrary to the UN Convention which states that orders are to be for the shortest period possible
- The issue is that the person is under proper, sufficient review so that if an order needs to be continued, it can be
- Extending an order to two years does not address the issue; proper monitoring of the persons health does

<u>Throughout the Act</u>

Issues • **Overcome stigma associated with the language** **Recommendations** • **Develop alternative term to mental dysfunction**
Comments • The ACT is alone in Australian jurisdictions in using mental dysfunction rather than mental disorder • The dysfunction provision in the ACT differs from the way mental disorder is defined in other jurisdictions • It makes sense to use the same terminology as other jurisdictions but need to ensure that the particular ACT context is considered.
Re Carers **Recommendations** • **Create provisions in the Act which allow for input from carers into treatment planning, and access to information about the treatment plan when appropriate. Provisions must sufficiently protect clinicians from litigation.** • **Consider the avenue for carers to appeal if they consider they are being excluded unreasonably from input into decisions.**
Comments • We need to wait till the Carers Working Group have finalised their deliberations • Some of the issues include clinicians being fearful of releasing information to carers • The Health Records (Privacy and Access) Act refers to carers involvement • Defining who is the primary carer is difficult; AAs may assist here. However, when a first episode occurs the person will more than likely not have an AA • Police are concerned re how to deal with a person over 18 if they are

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incapacitated; how do police inform the family?
<u>RE AAS</u> <u>Issues</u> • **Provisions for creating and enforcing AA's are confusing** <u>Recommendations</u> • **Clarify the process for making an AA, and how and when they may be applied** • **AAs should not be overly prescriptive, as the need to consider alternative treatments may arise and clinicians must be able to exercise professional judgement. AAs should not be drafted without good consideration of someone's possible future condition (ACAT)**
<u>Comments</u> • Views noted
<u>SUBMISSION C DECISION MAKING CAPACITY</u> <u>Issues</u> • **In the *Draft Explanatory Statement* decision making ability is defined as the ability to "clearly communicate a decision".** • **This discriminates against people with disabilities who may be unable to communicate clearly using conventional methods.** • **Capacity to clearly communicate a decision may not relate to a person's capacity to <u>make</u> decisions.** <u>Recommendations</u> • **A framework for determining decision making capacity must not include "clearly" (communicating a decision).** • **Rather it should include whether the individual:** **a) understands the information relevant to making a particular decision;** **b) uses and weighs that information as part of the decision-making process;** **c) appreciates the reasonably foreseeable consequences of the decision**

and of not making a decision;

d) makes the decision voluntarily; and communicates the decision (through any means), the person to be supported to use the most appropriate communication form to that person.

(also submission D)

Comments

- General agreement
- Discrimination Act refers to the necessity to make reasonable adjustment for disability
- Agreement that more work needed to see the language accommodates difference adequately

S 9(1)(a)(c) and (d)

Issues

- **Rejection of the idea of a person having no decision making capacity (DMC). DMC exists on a continuum; changing over time and context.**
- **The person with disability should be supported to make their own treatment decisions as far as possible each time a decision arises.**
- **DMC principles enshrined in Article 12 of the United Nations CRPD:** ***"States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity".***

Recommendations

- **Under new section 9 (1) (a) (c) and (d) the phrase "impaired decision-making capacity" should be used instead of "unable to make a decision" or "does not have capacity"**

Comments

- Support for this recommendation

S 9 (1)(b)

Issues

- To promote the person's right to receive medical treatment on the basis of free

and informed consent and right to be supported to exercise their legal capacity, person should:

- have as much *direction* over their treatment as possible, to the best of their ability.
- make their own choices and decisions rather than only being supported to contribute to these decisions.

Recommendations

- New Section 9 (1) (b) should state "must always be supported to have as much direction over treatment, care or support decisions to the best of the person's ability" instead of "contribute to".

Comments

- See Below

S 9 (1) (c)

Issues

- To ensure substitute decision making is a last resort, guidelines need to outline what constitutes "all practicable steps" to help a person make their decision about their mental health treatment or ongoing medication regime.

Recommendations

- A guide for undertaking "all practicable steps" under new Section 9 (1) (c) needs to be outlined, similar to *Essential Principles: Irish Legal Capacity* as follows:

- The best efforts must have been made to communicate with the person about the decision, through all possible means including alternative and appropriate communication formats;
- Every effort must have been made to understand the person's will and preferences;
- If there is no existing support network for that person one should be developed if possible;
- Every effort must have been made to provide information in a manner that the person can understand and all means of support (including advocacy) should

have been provided in order to help the person make a decision;

- These steps should be undertaken for every decision.

Comments

- Police are concerned that a person subjected to involuntary treatment will later complain about police assault
- Presumption of capacity which legislation will promote should mean the police concern will not arise
- Ambulance service records assessment on each occasion a person is treated; this is particularly important if the treatment is recorded against the persons will
- Ambulance Service concerned this provision is too wide
- Support for these provisions in principle with a Code of Practice to serve as guidance
-

Date: **Tuesday 9 November 2012**
Time: **9.30am- 11.30am**
Location: **Conference Room, Level 3 11 Moore St**

Actions

Action 1

At next meeting: Part One submission summary to be discussed from Point 14

THE ACT MENTAL HEALTH (TREATMENT AND CARE) ACT (1994) REVIEW ADVISORY COMMITTEE MEETING

MEETING MINUTES

Date: **Wednesday 21 November 2012**
Time: **2.15pm- 4.15pm**
Venue: **Training room 1, 1 Moore St**

Welcome	Meeting opened at 2.20pm. Steve Druitt welcomed RAC Members and chaired the meeting until 3.20 at which point Richard Bromhead assumed the Chair.

Attendees	
Steve Druitt	Project Manager Review Mental Health Act (1994) ACT HD
Richard Bromhead	Manager Mental Health Policy and Planning Unit, HD
Linda Crebbin	ACAT
Jon Wood	ACT Ambulance Service
Simon Viereck	Mental Health Community Coalition
Anita Phillips	Public Advocate ACT
Denise Caldwell	Public Advocate ACT
Craig Allatt	Carers ACT
Doris Kordes	Carers ACT
Dalane Drexler	CEO, ACT Mental Health Consumer Network
Megan Sparke	JACS
Victor Martin	JACS
Andrea Touaji	JACS
Sean Costello	Human Rights Commission
Kate Harkins	JACS
Pam Jenkins	JACS
Sgt Greg Booth	AFP
Renate Moore	CMCD
David Lovegrove	ACTMHCN Consumer rep
Sue Watson	Community Services Directorate (Disability)
John Hinchey	VOCC
Peter Norrie	MHJHADS
Len Lambeth	MHJHADS
Fleur Joyce	Mental Health Policy and Planning Unit, ACT Health (Secretariat)

Apologies	
Julia Bocking	Consumer Consultant MHJHADS
Tina Bracher	ED, MHJHADS
Tony Malone	ACT Corrective Services
Dee McGrath	CEO Carers ACT
Mary Durkin	Disability and Community Services Commissioner
Kate Starick	Community Services Directorate(Disability ACT)
Ian Rentsch	Executive Officer, Mental Health Community Coalition
David Snell	JACS
Hugh Jorgensen	JACS
Zoe Pope	AFP
Ross O'Donoghue	Policy and Government Relations, HD
David James	CMCD, Social Policy and Implementation
Bernadette Mitcherson	Corrective Services

Actions arising from last meeting

Part One submission summary to be discussed from Point 14.

Victor Martin reported that the outcomes from discussion about forensic provisions at the previous meeting would be dealt with in the context of the second exposure draft but noted that search powers would be addressed reflecting AFP concerns raised at previous meeting. JACS to follow up with the HRC for discussion about outstanding matters.

ACTION 1

Issue 2 from Part 1 of Submission Summary document was revisited by MHPU seeking RAC support for suggested response to issues previously raised around assessment process in circumstances where ACAT holds serious concerns for safety of applicant for assessment once subject person is notified of assessment order.

RAC **supported** the proposed shortening of the assessment process whereby ACAT notify the mental health service of the concern and may order an emergency assessment.

RAC **did not support** immediate apprehension of the person.

RAC **did not support** inclusion of clause (a)

ACTION 2

Issue 5 (S37(1))

Ambulance powers. It was suggested that the legislation would simply provide an apprehension power for ambulance paramedics with no power to use force, details of which service attends

when to be subject to inter-service agreement. A further meeting with Ambulance ACT, AFP, JACS, MHPU and the Chief Psychiatrist to discuss particular issues and report back to RAC. ACTION 3
Issue 6 A Carers working group has been established. GSO will provide legal advice by 5 December and the WG will meet to discuss. WA's new bill includes carer provisions, which MHPU will distribute. Recommendation at Issue 6 **not supported** by RAC. Need for review of patient history including at cessation of Treatment Order should be accommodated in clinical procedures. ACTION 4
Issue 7 RAC **supported** use of term Mental Disorder rather than Mental Dysfunction ACTION 5
Issue 8 police obligations to pass on information to family member who is also a victim under the VOC Act is compromised when excluded from ACAT procedures. Linda Crebbin advised existing but awkward process to allow passing on of information in such circumstances. Requires amendment of MHA to discharge police from obligation under VOC Act. JACS to take up in forensic provisions. RAC **supported** action in this matter. ACTION 6
Issue 13 AFP reported minutes of last meeting inaccurate as Court not bound by ACAT findings. JACS to clarify through Explanatory Statement. ACTION 7
Issue 14 Recommendation **supported** by RAC

ACTION 8
Issue 15 Where compliant but non-capacious person has consent provided by guardian other than PA RAC concerned that there is no other oversight of that consent to ensure guardian consent is not abusive. RAC **supported** PA having a notification and monitoring role in these circumstances. This role would be consistent with PA's current role to oversee other restrictive practices. The treating Team will have responsibility to notify PA and the period consent to be no longer than that allowable for a PTO. ACTION 9
Issue 16 RAC concluded that where the PA is the guardian there is no further need for oversight. MHPU recollection is that RAC has previously agreed (2 meetings prior to this one?) that where non-capacious but compliant person has no guardian, consideration should be given to applying for a guardian to be appointed, so that consent for psychiatric treatment can be given without a PTO being imposed. If there is no one else suitable or available, the Public Guardian could be appointed guardian. Noted that some international mental health legislation include provision for consumer to nominate a person to accompany them though the mental health system. ACT MHA has mention of representative person. NO ACTION
Meeting closed. next meeting Wednesday 28 November 2012 at 11 Moore St, ground floor conference room.

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THE ACT MENTAL HEALTH (TREATMENT AND CARE) ACT (1994) REVIEW ADVISORY COMMITTEE MEETING

MEETING MINUTES

Date: **Wednesday 28 November 2012**
Time: **9.15am- 11.15am**
Venue: **OCYFS Conference Room**

Welcome	Meeting opened at 9.20pm. Richard Bromhead welcomed RAC Members.

Attendees	
Richard Bromhead	Manager Mental Health Policy and Planning Unit, HD
Linda Crebbin	ACAT
Simon Viereck	Mental Health Community Coalition
Anita Phillips	Public Advocate ACT
Denise Caldwell	Public Advocate ACT
Craig Allatt	Carers ACT
Dalane Drexler	CEO, ACT Mental Health Consumer Network
Amanda Davies	Policy Officer, ACT Mental Health Consumer Network
Megan Sparke	JACS
Victor Martin	JACS
Sean Costello	Human Rights Commission
Matt Hingston	Human Rights Commission
Kate Harkins	JACS
Sgt Greg Booth	ACT Policing
Zoe Pope	ACT Policing
S/c Cath Gough	ACT Policing
Christina Ryan	Advocacy For Inclusion
Renate Moore	CMCD
David Lovegrove	ACTMHCN Consumer rep
Peter Norrie	MHJHADS
Bill Kerley	Proxy for Doris Kordes Carers ACT
Fleur Joyce	Mental Health Policy and Planning Unit, ACT Health (Secretariat)
Amanda Charles	Disability ACT

Apologies	
Steve Druitt	Project Manager Review Mental Health Act (1994) ACT HD
Jon Wood	ACT Ambulance Service
Doris Kordes	Carers ACT
Julia Bocking	Consumer Consultant MHJHADS
Tina Bracher	ED, MHJHADS
Pam Jenkins	JACS
Sue Watson	Community Services Directorate (Disability)
John Hinchey	VOCC
Tony Malone	ACT Corrective Services
Dee McGrath	CEO Carers ACT
Mary Durkin	Disability and Community Services Commissioner
Kate Starick	Community Services Directorate(Disability ACT)
Ian Rentsch	Executive Officer, Mental Health Community Coalition
David Snell	JACS
Hugh Jorgensen	JACS
Ross O'Donoghue	Policy and Government Relations, HD
Bernadette Mitcherson	Corrective Services
Rosemary Agnew	ACT Medicare Local
Herb Krueger	MHJHADS
Catherine Fox	Consumer Consultant MHJHADS

Actions arising from meeting

Part Two submission summary to be discussed from Issue 6 at next meeting.

JACS to organise meeting of Greg Booth, Victor Martin, Richard Bromhead, Peter Norrie and Jon Wood to discuss Ambulance Officer apprehension powers.

Linda Crebbin to meet with Legal Aid to discuss need for further detail in the listing notice to address consumer and their representatives/advocates with the necessary information to appear and respond. Also to discuss including information about availability of legal aid services if Legal Aid able to commit to provision of service. Linda to report at next meeting

All members to review best interests concept in WA and Vic legislation for next meeting.

Peter Norrie to explore capacity to provide review reports to ACAT 1 full week before review hearings.

Discussion of recommendations

Issue 17 from Part 1 of Submission Summary document discussed and supported by some. Point made that RAC had already decided that ACT would not move to pure capacity model and that the appropriate criteria for overriding consumer decision where consumer has capacity and does not

agree to treatment are those of risk, deterioration and/or harm.

It was noted that:

- in health matters other than mental health a person's right to refuse treatment is respected regardless of perceived best interests – autonomy paramount.
- the Health Attorneys Act addresses autonomy.
- the Best Interests test in .....(missed this) is substantially broader than risk, harm and deterioration so would significantly extend the circumstances where a consumer with DMC's wishes could be overridden.
- best interests is conceptually about people with no capacity or viewed as having no capacity. It is inherently paternalistic, value laden and subjective.
- Other jurisdictions are looking at best interests and should be considered.

RAC agreed to make **no change** at present. Members agreed to review Victorian and WA legislation and revisit the matter at the next meeting. (Actions arising)

NO IMMEDIATE CHANGE TO THE EXPOSURE DRAFT

Issue 18 (S37(1))

Ambulance powers were discussed at the last meeting. RAC reiterated its position noting:

- a health crisis requires a health response.
- Recovery and resolution of immediate health crisis is assisted by not involving police.
- Only where safety of person or public arises are police an appropriate response.
- Aspirational goal of the police is that all incidents having some level of risk assessment by suitably skilled personnel before calling police if risk of harm present.

RAC agreed that this particular recommendation is not suitable for inclusion in MHA and that reference to police as option of last resort is awkward way to address the acknowledged need. Ambulance officers need legislative protection in the MHA to avoid allegations of assault when having to apprehend a person who resists.

Issue is what level of power does a Paramedic require – that of mental health officer or police officer? JACS to organise meeting with Ambulance ACT, AFP, JACS, MHPU and the Chief Psychiatrist to discuss particular issues and report back to RAC. (Actions Arising)

NO IMMEDIATE CHANGE TO THE EXPOSURE DRAFT

Issue 19

The provision of information and documents about a case held by ACAT to consumers and their representatives is problematic. The ACAT Act requires that ACAT follow procedural fairness and natural justice principles. To withhold information from a subject person and their representatives requires a reason. In Review hearings the report is drafted with the understanding that it will be provided to the consumer and their representatives. The requirement is currently for the Review Report to be with ACAT 3 days before the hearing but

<table>
<tr><td>Peter Norrie would be agreeable to extending this to 1 week. (Actions Arising)

In inpatient hearings the ACAT currently receives no papers other than the application before the tribunal hearing. ACAT receives confidential clinical notes for current period of detention at hearings with no time usually to read them. These are provided by the Chief Psychiatrist Liaison Officer. Notes are usually not used but can be relevant and useful on occasion. other information might be submitted by families, in confidence sometimes placing the family member at risk were their action to be revealed.

Discussion noted:
• question arises as to whether ACAT should receive written clinical information or the clinician at tribunal hearings come with full knowledge of the case and prepared to outline in depth any clinical issues that arise in the course of the hearing?
• Health Records Act allows extended time for analysis of records before release to ensure no confidential information or the safety of any person is compromised so this ~~recommendation is unreasonable~~would need to be carefully considered.
• QLD clinicians hold two files on each case separating confidential information from a record that is available for inspection by the consumer and their representative.
• The application form is lacking in some detail that would better inform consumers and their representatives about the reason for the application of which they are the subject.
• Clinicians' role is to .... (I missed the point Peter Norrie made here – any recollections appreciated.)

Linda suggested she talk to Legal Aid about their submission and the intent of this recommendation to seek an alternative solution to the acknowledged issue. (Actions arising)

NO IMMEDIATE CHANGE TO THE EXPOSURE DRAFT</td></tr>
<tr><td>Issue 20

RAC supported the inclusion of the elements of DMC in the MHA.

Recommendation Supported</td></tr>
<tr><td>Issue 21

RAC agreed that the MHA could usefully include a general provision addressing the promotion of available legal advice to consumers.

ACAT agreed to review the listing notification document to include a statement about the availability of free legal advice for eligible people IF Legal Aid is able to commit to provision of a service (actions arising).

Amendment to the second exposure draft to reflect RAC's agreement is supported.</td></tr>
<tr><td>END OF PART ONE RECOMMENDATIONS.

PART TWO RECOMMENDATIONS ARE NUMBERED FROM 1</td></tr>
</table>

Issue 1

RAC has previously determined that DMC would be paramount except where overriding factors of risk, harm or deterioration are present in which case a Treatment Order will be issued.

RAC **agreed** that an assessment of DMC should be undertaken regardless of the age of the subject person and that the Gillick Principle would be referenced in the legislation.

RAC supported amendment of second exposure draft to reference the Gillick principle.

Issue 2

RAC **agreed** that the MHA should generally be structured in accordance with current PCO drafting convention.

RAC **agreed** that the section specific definitions should be moved to the front of the section to which they apply.

Recommendation to move section specific definitions is supported

Issue 3

Discussion noted

- need to ensure a readable Act
- need for consistency with ACT legislation drafting practice
- reluctance to put the substantive matters at the back of the Act and the machinery and other matters at the front to avoid perception that we seek to 'hide' the more confronting material behind non-controversial matters.
- Chapter 8 is misnamed – not about rights in general

Carers ACT noted liking for the WA Green Bill's inclusion of Carer Rights section and desire to see similar provisions in the second exposure draft.

Advocacy for Inclusion noted dissatisfaction with the WA Green Bill and intention to challenge it. A4I would not like it to be used as reference point for second exposure draft.

RAC **agreed** to give AAs a dedicated chapter and move them to the front of the Act with principles and objectives.

RAC **agreed** to rename Chapter 8 and Part 8.1 to correctly reflect their application to *admitted* people.

Amendment to second exposure draft to reflect RAC agreed actions above is supported.

Issue 4

Voluntary Patients

Generally MHA are not service Acts, historically reflect progressive tightening of previously unfettered powers to subject people to coercive treatment.

RAC considered that the ES could usefully include statement about the fact that general health laws apply equally to mental health consumers except with inconsistent with the MHA.

Some RAC members suggested that there was a desire to move away from an Act that is primarily concerned with regulation of involuntary psychiatric treatment and understood this to be the intention of the review. Other RAC members suggested that including a dedicated section on voluntary mental health consumers would in fact further stigmatise them by virtue of them being legislated about and that this would be an inappropriate change.

It was noted that the disability Act includes a section on the rights of all health consumers with a disability and this includes psychiatric illness.

Recommendation is not supported

Issue 5

ACAT proposed that some of the concerns raised by the previous issues around autonomy, DMC and the general feel of the Act might be addressed by rewriting sections 38 and 46 (PTOs and CCOs) to strengthen the position of DMC as a threshold issue as intended by the original work of the DMC working group.

RAC **agreed**. DMC Working Group members to reactivate original assessment flowchart.

Amendment to second exposure draft to place DMC at forefront of sections on orders is supported.

Meeting closed.

next meeting is on Friday 30 November 2012 at 11 Moore St, in the ground floor conference room from 11am – 1pm.

DRAFT

THE ACT MENTAL HEALTH (TREATMENT AND CARE) ACT (1994) REVIEW ADVISORY COMMITTEE MEETING

MEETING MINUTES

Date: **Friday 30 November 2012**
Time: **11 – 1 pm**
Venue: **OCYFS Conference Room**

Welcome	Meeting opened at 11:00am. Ross O'Donoghue was in the Chair and welcomed RAC Members and acknowledged the traditional owners of the land. Ross handed over to Richard Bromhead at 12:30.

Attendees	
Ross O'Donoghue	Policy and Government Relations, HD
Richard Bromhead	Manager Mental Health Policy and Planning Unit, HD
Linda Crebbin	ACAT
Simon Viereck	Mental Health Community Coalition
Christina Thompson	Public Advocate's Office ACT
Dalane Drexler	CEO, ACT Mental Health Consumer Network
Amanda Davies	Policy Officer, ACT Mental Health Consumer Network
Victor Martin	JACS
Andrea Tokaji	JACS
Matt Hingston	Human Rights Commission
Pam Jenkins	JACS
Sgt Greg Booth	ACT Policing
Christina Ryan	Advocacy For Inclusion
Renate Moore	CMCD
David Lovegrove	ACTMHCN Consumer rep
Peter Norrie	MHJHADS
Bill Kerley	Proxy for Doris Kordes Carers ACT
Jon Wood	ACT Ambulance Service
Fleur Joyce	Mental Health Policy and Planning Unit, ACT Health (Secretariat)
John Hinchey	VOCC

Apologies	
Steve Druitt	Project Manager Review Mental Health Act (1994) ACT HD

Amanda Charles	Disability ACT
Sean Costello	Human Rights Commission
Anita Phillips	Public Advocate ACT
Doris Kordes	Carers ACT
Julia Bocking	Consumer Consultant MHJHADS
Tina Bracher	ED, MHJHADS
Tony Malone	ACT Corrective Services
Mary Durkin	Disability and Community Services Commissioner
Kate Starick	Community Services Directorate(Disability ACT)
Hugh Jorgensen	JACS
Megan Sparke	JACS
Bernadette Mitcherson	Corrective Services
Craig Allatt	Carers ACT
Catherine Fox	Consumer Consultant MHJHADS
Jane Caruano	JACS

Minutes of the last meeting

The minutes of the Meeting of 28 November were passed with one clarification. Jon Wood, ACT Ambulance, clarified that Ambulance Officers have powers consistent with those of police to apprehend.

Actions from last meeting

A meeting of JACS, AFP, MHPU, the Chief Psychiatrist and ACT Ambulance was organised for after the meeting of 30 November 2012.

Linda Crebbin met with the deputy CEO of Legal Aid to discuss the possible inclusion in the listing documentation of information about available legal services. Linda reported that LA did not believe the intention of their submission was well reflected in the submission summary document and will draft a more specific proposal that could be usefully included in the Code of Practice Protocol document that is planned. With regard to the provision of documentation to legal representatives prior to hearings Linda is yet to talk with a particular officer who is not available at present.

All members reviewed the best interests concept as outlined in WA and Vic legislation in preparation for today's meeting.

Peter Norrie's efforts to explore capacity to provide review reports to ACAT 1 full week before review hearings are ongoing.

Actions arising from this meeting

1. Linda Crebbin to advise MHPU of any required technical changes to facilitate ACAT's use of the Act's provisions for inclusion in the 2nd exposure draft.

2. Victor Martin to provide advice and words to the MHPU to address the need for an additional clause to enable the ACAT to make a PTO when an application for a forensic order is rejected.

3. MHPU to explore most appropriate place for assessor requirement to indicate availability of treatment and care – the Act or the CofP

4. RAC members to consider and advise on words other than 'reasonable', in respect of *judgement*, and 'do something necessary' in s9(d) to achieve a better fit with the DMC framework.

5. Pam Jenkins to seek advice and report to RAC on consistency of Emergencies Act provisions on emergency apprehensions by paramedics with the Human Rights Act.

Discussion of recommendations

The Chair reported that issues 6 - 8 of Submission Summary Part 2 have been substantially dealt with in previous discussions and expressed the view that the planned Code of Practice (CofP) and its detailed procedures, including capacity assessments, could be dealt with by Regulation.

ACTMHCN queried whether the detail of the CofP sufficiently addressed the concerns raised in these issue recommendations which go to the need for the Act to put DMC (and therefore an assessment of that) front and centre of the process leading to treatment and care decisions. ACTMHCN believes that capacity should not only be tested at the point of considering an order.

RAC members noted:

- Capacity is assumed unless evidence provided to the contrary. Lack of DMC must be proven.
- All health services require informed consent.
- Perhaps there is an appropriate difference between formal testing and informal assessment of capacity, the former to be a precursor to an consideration of the need for an order and the latter to be an ongoing practice occurring regularly as part of the consumer/practitioner relationship.
- Capacity should be considered regularly, for example when treatment changes.
- The amendments discussed and agreed at the previous meeting, that will put assessment of DMC before assessment of risk and need for an order, will address the need for increased emphasis in the Act on the practical manifestation of the DMC principles.

RAC agreed that the changes already proposed and the CofP will address the concerns of this submission with regard to the need for a detailed description of capacity assessment.

No further change to the exposure draft on this matter.

Section 44 (1)(a) says that if the Chief Psychiatrist determines that the ACAT would no longer make the same order then the order is revoked. The two different elements to be considered are not well reflected in this section – capacity and risk/harm/deterioration. It would be useful for the section to express more clearly the process of determining that the ACAT would no longer make the same order, ie that where a person regains capacity but the Chief Psychiatrist believes the risk/harm/deterioration element is still present then the ACAT should be advised and should make a new decision.

RAC supported amendment of S44(1)(a) to reflect the discussion above.

ACAT raised a technical change to ensure that the 'review' sections include an opening statement to outline the circumstances in which the section applies. Linda Crebbin to supply text and additional similar technical changes to the MHPU for inclusion in the 2nd exposure draft. (actions arising)

RAC agreed that the technical change requested by ACAT be included in the second exposure draft.

JACS requested that an additional clause is required to enable the ACAT to make a PTO when an application for a forensic order is rejected. Victor Martin to provide further advice to the MHPU (actions arising).

Issue 10-12

MHCC questioned need for consumer to apply for an order against themselves when by definition they are voluntarily engaged with the mental health system and are seeking treatment. Concerned that rather than having to seek an order to ensure practitioners supply needed treatment, the needed services ought to be more readily available and accessible.

The requirement for a person to consent to an assessment order also seems unnecessary.

Inclusion of the forensic referral for assessment order with the equivalent civil provisions is concerning and possibly stigmatising.

RAC noted that:

- the 'own' order provision is rarely used and sees no particular harm in its presence
- the requirement for a subject person's consent to an assessment order can be useful because it obliges follow through on the resulting report which is provided to ACAT and forwarded to the subject person.
- The provisions at ss9(f) and (g) are about diversion to a therapeutic response for someone who has come to the attention of the justice system for *some* reason. There is an assumption of innocence at this stage
- The assessment procedures are grouped together - normalisation is a reasonable approach to challenging stigma.

No immediate change to the exposure draft.

Issue 13

The provision of information about proposed treatment to the ACAT is critical to enable the ACAT to draw conclusions about least restrictive practices. Currently, the Chief Psychiatrist and Care Coordinator are required to lodge their treatment plans with the ACAT but this occurs after the application is heard by the ACAT.

RAC noted that:

- The old provisions that allow for anyone to apply for an order will change in the new Act to allow only particular people to apply so a requirement to submit a proposed treatment plan *with* the application for an order will be effective.
- the assessment order requires the assessor to indicate what treatment and care is available to the consumer but this is not reflected in the provisions of the Act.
- The ACAT cannot judge the treatment and care plan per se, only satisfaction of the least restrictive criteria requirement

RAC agreed that the proposed Treatment and Care Plan should be included with a mental health order application and sought clarification about whether the requirement of the assessor to indicate availability of treatment and care should be reflected in the Act or the CofP.

MHPU to explore most appropriate place for assessor requirement to indicate availability of treatment and care – the Act or the CofP (actions arising).

RAC supported amendment of the second exposure draft to require proposed treatment and care plan to be included in application for a mental health order.

Issue 14

Capacity of consumers to dispute treatment and care queried. Difficulty reported anecdotally in getting second opinions. Particular difficulties experienced are where:

1. a specialist regards any other medical appointments during the process of engaging with the mental health system as opportunities for second opinions; and
2. general practitioners suggest or state that because particular treatment is part of their plan and subject to an order then there is no provision for another opinion and will not provide a referral.

RAC noted that the Charter of Rights of Mental Health consumers (ACT) and the Australian Charter of Healthcare Rights are clear about the rights of consumers to a second opinion.

The Chief Psychiatrist was clear that the second particular problem is not correct and that the consumer's case manager in the first instance and he, in the second, would be the appropriate people to contact if consumers present to consumer rep orgs with this problem. A PTO does not displace existing rights.

No immediate change to the exposure draft.

Issue 15

Carers Working Group (CWG) is ongoing and will provide feedback to RAC when it has met and developed its position.

HRC noted that the Health Services Commissioner believes that the Health Records Act (HRA) allows appropriate sharing but is happy to have something specific in the MHA that is consistent with the HRA. This is supported by the AFP.

However, MHPU noted concerns about legislation drift whereby the provisions in one act are later amended and so begin to differ from the Act in which those provisions were originally replicated. MHPU regards it as better practice to refer to the original Act in the new Act or use the CofP to outline the intended approach to information sharing.

RAC noted:

- important not to erode rights of consumers or adopt position whereby a person other than the consumer is presumed to be the person to receive information.
- The ACT has a Human Rights Act in which an individual's privacy has primacy.

No immediate change to second exposure draft.

Issue 16

ECT provisions previously canvassed and position reached is already among the most stringent and much more restrictive than the current Act. The Working Group concluded that the ACT has more 'other' protections than jurisdictions that adopted a total ban.

No Change to second exposure draft.

Issue 17

Membership of the Treating Team requires clarification as the Health Records Act is inadequate in our case. Membership should be defined clearly.

RAC noted that the wording around AAs is unclear there is confusion s to what may be covered in an AA. Provisions require rewriting to clarify what is binding and whether all of the people who are implicated in an AA are required to sign the AA. Purpose of AA as doc to cover any actions that affect treatment must be clear.

RAC supported amendment to AA provisions in the second exposure draft to clarify the purpose and process re AAs.

Issue 18

These issues have been subject of discussion previously. No further discussion required.

Issues 19 and 20 Matters with subject to PCO. **No Immediate change to second exposure draft.**
Issue 21 RAC heard that words other than 'reasonable', in respect of *judgement*, and 'do something necessary' are required in s9(d) to achieve a better fit with the DMC framework. **RAC agreed to consider this at a future meeting in the absence of any suitable replacements being suggested (actions arising).**
Issue 22 The assessment order form should include requirement assessment of DMC after assessment of mental illness. RAC noted the forms are part of the CofP rather than the Act but **agreed** it would be appropriate.
Issue 23 Ambulance ACT expressed concern that proposal at issue 23 would override existing provisions for emergency apprehensions which are covered under the Emergencies Act. Pam Jenkins to seek advice and report to RAC on consistency of Emergencies Act provisions in this regard with the Human Rights Act (actions arising) **RAC did not support the recommendation.**
Meeting closed at 1pm. The next meeting is on Wednesday 5 December 2012 at 11 Moore St, in the LEVEL 3 conference room from 12.45 – 2.45 pm. Part Two submission summary to be discussed from Issue 24.

Review of the ACT Mental Health Act Review Advisory Committee

AGENDA

Wednesday 5 December 2012

Conference Room, Level 3, 11 Moore Street

12:45pm – 2:45pm

1 **Welcome and Introductions for any new participants**

2 **Attendance and apologies**

Participants to sign attendance sheet circulated at the meeting.

3 **Minutes of last meeting**

Draft minutes circulated Tuesday 4 December.

4. **Actions arising from last meeting**. The Actions Arising are included at the front of the Minutes from 30 November meeting.

5 **Continue discussion of recommendations arising from submissions to public consultation on First Exposure Draft.**

Discussion will commence at Issue 24 in Part 2 of the Submissions Summary document circulated prior to last meeting.

6 **Next Meeting**

Wednesday 7 December Ground Floor Conference Room, 11 Moore St.

Review of the ACT Mental Health Act Review Advisory Committee

AGENDA

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Conference Room, Level 3, 11 Moore Street

12:45pm – 2:45pm

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Discussion will commence at Issue 24 in Part 2 of the Submissions Summary document circulated prior to last meeting.

6 **Next Meeting**

Wednesday 7 December Ground Floor Conference Room, 11 Moore St.

Review of the ACT Mental Health Act Review Advisory Committee

AGENDA

Wednesday 28 November 2012

Conference Room, Ground Floor, 11 Moore Street

9:15 – 11:15am

1 **Welcome and Introductions for any new participants**

2 **Attendance and apologies**

Participants to sign attendance sheet circulated.

3 **Continue discussion of recommendations arising from submissions to public consultation on First Exposure Draft.**

Discussion will commence at Issue 17 in Part 1 of the Submissions Summary document.

4 **Next Meeting**

Friday 30 November OCYFS Conference Room, ground Floor, 11 Moore St.

THE ACT MENTAL HEALTH (TREATMENT AND CARE) ACT (1994) REVIEW ADVISORY COMMITTEE MEETING

MEETING MINUTES

Date: Wednesday 5 December 2012
Time: 12:45 – 2:45 pm
Venue: Level 3 Conference Room, 11 Moore St

Welcome	Meeting opened at 12:45pm. Richard Bromhead was in the Chair and welcomed RAC Members. Richard handed over to Ross O'Donoughue at 1:15pm.

	Name	Organisation
ATTENDEES	Ross O'Donoghue	Policy and Government Relations, HD
	Richard Bromhead	Manager Mental Health Policy and Planning Unit, HD
	Linda Crebbin	ACAT
	Anita Phillips	Public Advocate ACT
	Denise Caldwell	Public Advocate's Office
	Simon Viereck	Mental Health Community Coalition
	Amanda Davies	Policy Officer, ACT Mental Health Consumer Network
	Victor Martin	JACS
	Andrea Tokaji	JACS
	Matt Hingston	Human Rights Commission
	Sean Costello	Human Rights Commission
	Sgt Greg Booth	ACT Policing
	Christina Ryan	Advocacy For Inclusion
	Renate Moore	CMCD
	Peter Norrie	MHJHADS
	Bill Kerley	Proxy for Doris Kordes Carers ACT
	Jon Wood	ACT Ambulance Service
	Fleur Joyce	Mental Health Policy and Planning Unit, ACT Health (Secretariat)

	Name	Organisation
APOLOGIES	Steve Druitt	Project Manager Review Mental Health Act (1994) ACT HD
	Amanda Charles	Disability ACT
	Doris Kordes	Carers ACT
	Mary Durkin	Disability and Community Services Commissioner
	Bernadette Mitcherson	Corrective Services
	Craig Allatt	Carers ACT
	Catherine Fox	Consumer Consultant MHJHADS

Minutes of the last meeting

The minutes of the Meeting of 30 November were accepted with two amendments.

Jon Wood, (ACT Ambulance) was noted as making a clarification to Ambulance Officers powers discussion in the minutes of the previous meeting. This discussion related to issue 18 of the Submission Summary Part 1 and as there was no change sought to the second exposure draft no amendment to the minutes of the meeting of 28 November was required.

At actions arising number 5 Pam Jenkins was noted as seeking advice about consistency of the emergencies act with the Human Rights Act. Human Rights Act should instead have been, 'the operational protocol to the convention against torture' (OPCAT).

Progress on actions arising from meeting of 30 November 2012.

1. Linda Crebbin to advise MHPU of any required technical changes to facilitate ACAT's use of the Act's provisions for inclusion in the 2nd exposure draft - ONGOING

2. Victor Martin to provide advice and words to the MHPU to address the need for an additional clause to enable the ACAT to make a PTO when an application for a forensic order is rejected. - ONGOING

3. MHPU to explore most appropriate place for assessor requirement to indicate availability of treatment and care – the Act or the CofP - ONGOING

4. RAC members to consider and advise on words other than 'reasonable', in respect of *judgement*, and 'do something necessary' in s9(d) to achieve a better fit with the DMC framework – FURTHER DISCUSSION AT FOLLOWING MEETING – TO SEEK DRAFTING ADVICE AS TO FORM OF WORDS THAT WOULD PROVIDE FOR LESSER STANDARD OF CRITERIA FOR LAYPERSON TO SEEK ASSESSMENT ORDER THAN REQUIRED IN CASE OF A RELEVANT PERSON AS DEFINED

5. Pam Jenkins to seek advice and report to RAC on consistency of Emergencies Act provisions on emergency apprehensions by paramedics with the OPCAT. – JACS ADVISED AT FOLLOWING MEETING THAT ANY AMENDMENTS REQURIED TO ENSURE CONSISTENCY WOULD BE MANAGED IN THE USUAL MANNER AND THAT THIS IS NOT SOMETHING RAC NEEDS TO BE CONCERNED ABOUT AT THIS STAGE.

Actions arising from this meeting

MHPU to circulate flow chart for order making process to RAC members

Discussion of recommendations from issue 24

Issue 24

RAC supported a recommendation to Government to undertake a review of the Guardianship Act.

Issues 25-27

These matters have been addressed under previous items and require **no further discussion.**

Issue 28 This issue related to resourcing for an education and information program about the changes to the Act. Late commencement clauses are included in the first exposure draft to allow for such a program. View put that 6 months is optimum time for such clauses to reduce likelihood of confusion arising for those who use the provisions daily. Resourcing of the education program acknowledged as critical to achieve desired outcomes in that timeframe. **No change to first exposure draft.**
Issue 29 - 31 These matters have been addressed under previous items and require **no further discussion.** MHPU to circulate flow chart for order making process to RAC members. (actions arising)
Issue 32 This issue related to sections 9(c) (d) and 10 in the amendment bill (Sections 12, 13 and 29 in the mock up) and requests consideration of the language of "reasonable judgement" which is viewed as inconsistent with the overall intention to remove as many subjective clauses from the legislation as possible. RAC agreed in respect of s10 (s29 in the mock up) and supported amendment of the first exposure draft to require that an application for a mental health orders requires that a current assessment has determined that a subject person has a mental illness or disorder and cannot be treated voluntarily and there is unacceptable level of risk/harm/deterioration. RAC did not agree that sections 9(c) and (d) (12 -13 in the mock up) require amendment in the same way but noted the general concern about use of language such as reasonable judgement to reflect the ordinary judgement of an ordinary person in the street which is the intention in these sections and agreed that the sections should be amended in line with advice from PCO about another form of words. **RAC supported amendment of ss 9(c) (d) and 10 (amendment bill) of the first exposure draft to reflect agreements noted above.**
Issue 33 Advance Agreements. RAC previously agreed that the AA provisions should be clarified for purpose, process and treating team membership. (see minutes 30 November 2012, issue 17.) RAC noted that AAs can include consent/non-consent matters, for example in respect of particular treatments, as well as wishes and preferences RAC is unsure how PCO would define 'wishes' or 'ways in which' **RAC supported amendment of AA provisions to be as specific as possible in all respects.**
Issue 34 Many aspects of this issue have been discussed previously. Some concern over the intersecting of AA, powers of Attorney, guardianship and nominated person provisions.

Discussion included questions such as: • does a nominated person in an AA or a subsequently appointed guardian take precedence? • does it change if the guardian was appointed before the AA was made in which a nominated person is described? • can a person on a guardianship order have an AA? **RAC supported amendment of the first exposure draft to clarify the relationship between these various powers.**
Issue 35 These issues have been subject of discussion previously. **No further discussion required**.
Issue 36 **RAC supported amendment to membership of the Mental Health Advisory Council to require both a consumer and a carer.**
Issue 37 Discussed at issue 28.
Issue 38 Previously addressed. **No further discussion required.**
Issue 39 **RAC supported amendment of first exposure draft to include preliminary statement at front of objectives to say that any entity exercising powers granted under this Act will have regard to the principles and objects of the Act**.
Issues 40-45 Previously addressed. No further discussion required.
Issue 46 This issue related to the question of which has precedence if a power of attorney and an AA are made while a person is capacitous. The proposed amendment bill deals with this matter already. A Power of Attorney must take into account a person's AA and the Power of Attorney overrides the AA to the extent that there is an inconsistency. No further amendment is required.
Issue 47 Previously addressed. No further discussion required.

Issue 48
Issue 48 RAC noted that the Health Records Act definition of a treating team is not sufficient and the MHA should be more specific. MHA definition of mental health professional is too broad and also requires narrowing but perhaps not so much that it removes all community based providers? **RAC made no specific recommendation so MHPU to consider.**
Issue 49 Issue previously discussed at Issue 48. No further discussion required.
Issue 50 Previously addressed. No further discussion required
Issue 51 **RAC supported amendment to the first exposure draft to enable the Minister for Health to seek advice on a specific matter relating to mental health from the Mental Health Advisory Council.**
Issue 52 Previously addressed. No further discussion required
Issue 53 This is a drafting issue and should be left to PCO.
Issue 54 RAC **does not support** changing 'objects' to 'objectives' **RAC supported amendment of first exposure draft to change references to 'their communities of choice' to 'the communities of their choice' in the objectives.**
Issue 55 Inclusion of ' serious disorders of streams of thought' was deliberate to ensure that people who currently display symptoms that now fit into mental dysfunction (which includes mental illness and others) but not within mental illness under the current act are not excluded from the definition of mental illness when mental illness and mental disorders are separated. RAC noted that there is no discussion in the ES about this change and requested that the ES be amended accordingly.

Issue 56

RAC agreed to delete reference to the CC from this amendment clause 10 (section 29 in the mock up) and recognises need to address the mechanism for moving from an assessment order to an application for a mental health order and who may make that application. Recognise need to include the PA in this section.

ACAT will provide a form of words to address this concern to MHPU. Proposed text will be circulated to RAC.

Issue 57

RAC supported amendment to the first exposure draft to cross reference section 250 at ss 35(b) and 36(f). PCO to advise on form

Issue 58

RAC supported amendment to the first exposure draft to remove a proposed change to the Act at amendment clause 27 which provides ACAT with an oversight role where it is not required and would be contrary to privacy requirements.

Issue 59

RAC supported reinstatement of section 36(1)(2) as it has been omitted from the first exposure draft inadvertently.

Issue 60

Delegations by the CC are covered by the Legislation Act. The CC has a different role from the CP and it would be impossible to specify a person, a class of person or a particular professional status.

Something about the Human rights Act – public authority – FIX

Issue 61

RAC supported amendment to the first exposure draft to include the PA as an information sharing entity at amendment clause 70.

The meeting closed at 2:45pm. It was agreed that RAC would not meet again but would receive advice about the carers' provisions by email.

Recommendations

Section 73(3) (c)

- **ES should detail specifically the limitation on the rights of children and young people of the proposed amendments, and how such limitations are reasonable.**

- **More clarity is required around an alleged offender who meets the definition under 73 (3) (c) – how long does ACAT have to make a decision, where are they held until that time?**

Comments

Recommendations

Affected people
s79(f)

- **Amend s 48Z(f) to reflect that an affected person should provide specific evidence to ACAT only on the matter of if the forensic patient were not detained, there would be risk of serious harm to others.**

Comments

Recommendations

s79(p)

- **Clarify the meaning of section 48Z(p) – is it meant to mean that the ACAT must take into account the views of the registered affected person as presented by the Victims of Crime Commissioner?**

Comments

Recommendations

s85(2)

- **This section specifies the action to be taken if a forensic psychiatric treatment order is no longer appropriate. In addition to the Chief Psychiatrist telling ACAT and the public advocate in writing the Victims of Crime Commissioner should also be told.**
- **An affected person should have the right to represent themselves in the Tribunal**
- **The ACAT should be required to give each affected person or the victims of crime commissioner, written information about the ACAT's decision, similar to the requirement of the Sentence Administration Board under s133 of the *Crimes (Sentence Administration) Act 2005.***
- **Provisions should be incorporated to govern the privacy and confidentiality of registered affected people such as section 192 in the *Crimes (Sentence Administration) Act 2005.* Specifically a provision should be included to provide that an affected persons contact details be withheld.**

Comments

Recommendations

Information sharing

- **Extra care should be taken to ensure that the legal rights and privacy of people with mental illness or dysfunction are not infringed by the information sharing. (Noted in two submissions).**

Comments

Recommendations

Correctional Patients

- **Clarify s108 – does it allow a detainee to be transferred without their**

consent to an approved mental health facility, with a detainee then having to seek a subsequent review from ACAT under s113? Submission advocates that section should only apply to consenting correctional patients. • Clarify where correctional patients will be transferred to from prison. • Clarify if Chapter 7, Correctional Patients applies to people on remand.
Comments
##
Recommendations **S 9J** **Issues** • An assessment order will now proceed automatically to consideration of a treatment order if the assessment indicates the need
Comments
Recommendations • The assessment order needs to provide this information to make the person aware of the process
Comments
S 9M # **Issues** • Currently there is no provision to formally advise MH services when ACAT, in the process of considering an application for assessment or order, have become concerned of increased risk to the person or others.

Recommendations

- **That the following provision be adopted in Bill:**

When the ACAT
a) is told by the applicant for an assessment order; or
b) becomes concerned in the process of considering an application for assessment or order
of a significant level of:
i) risk to the subject person's health or safety; or
ii) risk of serious harm to others
then the ACAT must as soon as possible, in writing, advise the Chief Psychiatrist of the risk

S 9M

Issues

- **Where the ACAT becomes aware that there is sufficient reasonable concern about risk to the person or others, including risk raised by issuing an assessment order, there is seen to be a need to minimise delay in assessment.**

Recommendations

- **Where the ACAT considers that the concern in # above is of sufficient level, they may make an order for assessment without notice, and require that the person be apprehended as soon as possible and taken to an approved mental health facility for assessment.**

S 53G

Issues

- **Ending an Advance Agreement: Consumer advocacy that consumers do not want to be able to withdraw their advance**
- **agreement when unwell and lacking capacity, as it would 'defeat the purpose'**
- **Advice that this does not at any rate correspond to a right to withdraw**

consent in the broader health environment

- (several stakeholders supported this change)

Recommendations

- Provide that a person may only end an Advance Agreement when they have decision making capacity

- The RAC to advise on whether, if the person resists treatment according to the AA, the treating team needs to apply for an Order so as to provide the treatment in the AA.

S 37 (1)

Recommendations

- Provide for Ambulance Paramedics to apprehend on the basis of assessment of medical risks. (They could ask for mental health assessment where needed)

- Indicate a 'hierarchy' of responders in emergencies – process?

- Provide for Ambulance Paramedics to apprehend under Section 37(2) instead of 37(1)

Submission (G)

Issues

- To enable longer term orders for where a person has a history of repeated relapse when taken off an order. Longer order will allow that they remain in treatment.

Recommendations

Create a classification of 'Chronic mental illness' (or dysfunction) (This recommendation and the one below

- came from a submission by a carer, see attached)
- Extend the maximum length of an Order to 2 years where a person is classified as having a chronic mental illness or dysfunction

- allow for review of this two year order at any time to be initiated by the person concerned and /or their legal advisor and /or advocate and /or by MH ACT and/ or the administrators of the Order.
- Provision be made to respond to vexatious applications for review of this order

Throughout Act
Issues

- Overcome stigma associated with the language

Recommendations

- Develop alternative term to mental dysfunction

Re Carers
Recommendations

- Create provisions in the Act which allow for input from carers into treatment planning, and access to information about the treatment plan when appropriate. Provisions must sufficiently protect clinicians from litigation.
- Consider the avenue for carers to appeal if they consider they are being excluded unreasonably from input into decisions.

Re AAs
Issues

- Provisions for creating and enforcing AA's are confusing

Recommendations

- Clarify the process for making an AA, and how and when they may be applied
  AAs should not be overly prescriptive, as the need to consider alternative treatments may arise and clinicians must be able to exercise professional judgement. AAs should not be drafted without good consideration of someone's possible future condition (ACAT)

Submission C
Decision Making Capacity

Issues

- In the *Draft Explanatory Statement* decision making ability is defined as the ability to "clearly communicate a decision".
- This discriminates against people with disabilities who may be unable to communicate clearly using conventional methods.
- Capacity to clearly communicate a decision may not relate to a person's capacity to make decisions.

Recommendations

- A framework for determining decision making capacity must not include "clearly" (communicating a decision).
- Rather it should include whether the individual:
  a) understands the information relevant to making a particular decision;
  b) uses and weighs that information as part of the decision-making process;
  c) appreciates the reasonably foreseeable consequences of the decision and of not making a decision;
  d) makes the decision voluntarily; and communicates the decision (through any means), the person to be supported to use the most appropriate communication form to that person.
  (also submission D)

S 9(1)(a)(c) and (d)
Issues

- Rejection of the idea of a person having no decision making capacity (DMC). DMC exists on a continuum; changing over time and context.
- The person with disability should be supported to make their own treatment decisions as far as possible each time a decision arises. DMC principles enshrined in Article 12 of the United Nations
- CRPD: "*States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity*".

Recommendations

- **Under new section 9 (1) (a) (c) and (d) the phrase "impaired decision-making capacity" should be used instead of "unable to make a decision" or "does not have capacity"**

S 9(1)(b)

Issues

- **To promote the person's right to receive medical treatment on the basis of free and informed consent and right to be supported to exercise their legal capacity, person should:**
- **have as much *direction* over their treatment as possible, to the best of their ability.**
- **make their own choices and decisions rather than only being supported to contribute to these decisions.**

Recommendations

- **New Section 9 (1) (b) should state "must always be supported to have as much direction over treatment, care or support decisions to the best of the person's ability" instead of "contribute to".**

S 9 (1) (c)

Issues

- **To ensure support for decision making is a last resort, guidelines need to outline what constitutes "all practicable steps" to help a person make their decision about their mental health treatment or ongoing medication regime.**

Recommendations

- **A guide for undertaking "all practicable steps" under new Section 9 (1) (c) needs to be outlined, similar to *Essential Principles: Irish Legal Capacity* as follows:**
- **The best efforts must have been made to communicate with the person about the decision, through all possible means including alternative and appropriate communication formats;**

- **Every effort must have been made to understand the person's will and preferences;**
- **If there is no existing support network for that person one should be developed if possible;**
- **Every effort must have been made to provide information in a manner that the person can understand and all means of support (including advocacy) should have been provided in order to help the person make a decision;**
- **These steps should be undertaken for every decision.**

Relationship to guardianship law- inferences re MHA

Issues

- **Supported decision making methods should be introduced to replace substitute decision making: Guardianship legislation is out-dated and not human rights compliant.**

Recommendations

- **Where a person is already deemed to have impaired decision making ability under the *Guardianship Act*, and their treatment under the new MHA is considered, impaired DMC should not be assumed for the current health decision, given deficiencies of Guardianship legislation.**

- **New section 9 (1) (c) must be applied for every decision irrespective of a person being already subject to a Guardianship order.**

S 9 (1) (c)

- **New section 9 (1) (c) must be applied for every decision irrespective of a person being already subject to a Guardianship order.**

- **Any health professional seeking consent from a guardian:**
- **must first check that the guardianship order relates to health decisions**

must be held accountable through legislative requirement.

MHA New section 142 (1A) and Guardianship Act New section 70 (1A).

Issues

- **Concern about the proposed amendments which allow a guardian to consent to treatment for mental illness. This places the *protected person* in a position of vulnerability, where mental health treatments do and will lack accountability**

- **When subject to a guardianship order a *protected person* is deemed to lack "capacity" and is extremely vulnerable. Failure to consider their concerns or discrediting their concerns denies their right to recognition before the law and to give consent on the basis of free and informed consent.**

- **People subject to a guardianship order for health decisions require a psychiatric treatment order (PTO) to access this treatment. In practice however, health professionals do accept consent by guardians for treatment of mental illness, even though this is in breach of the Act. This increases the vulnerability of the *protected person* and reduces oversight and accountability.**

- **It is not appropriate that a person should be subject to a PTO when they express willingness to receive treatment, yet this happens in practice.**

Recommendations

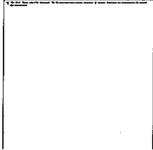
Support for:

- **Proposed amendments to the *Guardianship Act* under New section 70A**

- **Guardianship orders do not always serve consumer interests**

Issues

- **Guardianship orders necessitate an imbalance of power, unequal access to legal assistance and uneven valuing of knowledge in both procedure and outcome.**



Review of the Mental Health Act 1994
Second Exposure Draft
Public Consultation

MINUTES

Date: Monday 3 June 2013 9:00am

Subject: Second Exposure Draft - *Mental Health (Treatment and Care) Act* 1994 — RAC Meeting

Source: JACS – Andrea Tokaji – Legal Policy Officer- Criminal Law Group

Record of Consultation

1. Attendance Review Advisory committee members

Name	Role

2. Points of Discussion

Richard Bromhead opens the meeting

Steve Druitt introduces discussions/issues raised

- Advanced Agreements - concerns expressed re: commissions - AA made with conditions - the current model is solid and has been working with clinicians
- AA & guardianship remains in dispute, confusing and may need another discussion with the group concerned - will contact and have a follow up discussions
- MHA & Guardianship Act - a diagram provided to all attendees which depicts the interaction of the two Acts
- Concerns raised in relation to the elements of the forensic provisions

Commented [FJ1]: I don't think this reflects Steve's comments and I'm not sure what you mean by commissions. I think Steve just talked about AAs being an important part of consumer's right to determine their recovery process.

Commented [FJ2]: The confusion is not just around guardianship abnd the group will look at the AA provisions in total.

- In relation to detention, the prediction of future behaviour is a part of the conversation eg- similar to the discussion around suicidiality
- Tools that assess violence (risk) are extremely well researched - Len Lambeth

Commented [FJ3]: If specifying Len's view should also mention opposing view. Perhaps better to talk about there being some discussion about the efficacy of future risk assessment tools.

Victor Martin:

- addressed the forensic provisions in the Amendment Bill, specifically three issues:
- 1. Detaining of persons under an ACAT order
- Agree that when ACAT makes a detention order, that if the person has not been through the criminal process - the way the system works now – the person can be detained, until ACAT orders otherwise - acquitted, found not guilty by reason of mental impairment
- s308 of the *Crimes Act* gives guidance around this by defining the criteria for detention – an order for detention should be made as a last resort
- any recommendations made by the ACAT also considered in relation to orders
- consideration of limited authority
- Recognition that ACAT's ability to make such an order needs to exist for a narrow scope of cases - which addresses needs of the person
- 2. legal custody of a person under the CMA

Commented [FJ4]: Need to spell out

- look to other jurisdiction ie - Vic & Qld - so that person is in the actual custody of mental health as well as the legal custody
- 3. Safeguard of the disclosing of information of an affected person
- there is currently no limitation on how this information is being used - VOCC has suggested that there is an alternative to criminal provisions happy to address concerns

Steve Druitt:

- assessments of decision making capacity - steps considered - options for patients - checking the understanding of the patient - discussing consequences - it is a 6 page standardised form - has been seen as reliable
- Qn: International precedence? - an area that is growing quickly - is there anything we can refer to?
- re: decision making capacity Linda Crebbin - the legislation refers to 'assistance as necessary' - this is addressed on a case by case basis, and is a matter of jurisprudential interpretation and application (s7- meaning of decision making capacity)

Steve Druitt:

Commented [FJ5]: Realy steve acknowledged there is still discussion around the principles and the need, or not, for provisions within the body of the act to give tangible expression to the principles.

- carers - framework - rely on health records & *Privacy Act* - where a person does not have capacity- to share information with carer- carers may be at a disadvantage, as clinicians may be too narrow in providing information based on privacy concerns
- Principles around working collaboratively with clinicians and carers has been developed - recommendation to provide the principles within provisions into the Act

Richard Bromhead:

- the privacy of the info would lie with the consumer - anything shared outside of the Health Records Act - would require a proportionality test to apply

HRC:

- may suffice to signpost to the *Privacy Act* & *Health Records Act* in a note within the MHA - this issue is better addressed at a policy level
- Carers do have a hierarchy of appeals process available to them if they feel they have been unduly treated or not assisted - the final analysis being a court process- this has been a successful process for carers in the past
- may be helpful to re-open nominations to the AA working group - to reconvene and allow for further discussions
- Len Lambeth suggested to identify operational issues raised to be addressed eg - important principles within AA – a suggestion that the chief psychiatrists to be very active in this process

Steve Druitt:

- have discussed with Drs concerns raised - preparing a response now

Commented [FJ6]: Not sure what this refers to

Richard Bromhead:

- looking at sunrising the Act - it will not come into operation immediately, giving time for further discussions (~~12~~ 6 months implementation ~~time suggested~~intended)

- Qn: Are there resources tied to the implementation of the act?

- clinical areas of Health are giving due consideration to the ~~looking at what~~ resources ~~are~~ needed~~required~~

- ~~There is resource provision within the Act~~ The review of the Act has resources attached.

Richard Bromhead drew attention to the extremely short timeframe for finalising amendments to the second exposure draft because the deadline for the finalised cabinet submission is 26 July.

3. Further Considerations:

- To pull together AA working group
- Revisit legal advice for Carer provisions
- Legal custody as well as disclosure of information sanctions to be resolved

4. Follow up action:

~~Deadline for comments to RAC is the 26 July 2013~~

- Next RAC meeting is 12 June 2013

Review of the ACT Mental Health Act
Review Advisory Committee

AGENDA

Wednesday 12 June 2013
Ground Floor Conference Room, 11 Moore Street
10.15am

1 Welcome and Introductions for any new participants

2 Attendance and apologies

Participants to sign attendance sheet circulated at the meeting.

3 Minutes of last meeting

meeting notes prepared by Andrea Tokaji (JACS) circulated previously.

4. Actions arising from last meeting.

The Advance Agreements working group reconvened and has prepared some alternative provisions to clarify the section. These provisions and comments to be tabled.

5 discussion of recommendations arising from public consultation on second Exposure Draft.

a. Items in grey have received agreement from all members who have responded so far. specific questions will be addressed rather than general discussion on these matters.
b. Remaining items will be dealt with in order as far as possible
c. AA provisions

NB: new items (highlighted yellow) have been inserted with the same item number as the item before them but with an (a) to keep the original items numbering intact.

6 Next Meeting

No additional meetings are scheduled. Remaining issues will be dealt with out of session.

THE ACT MENTAL HEALTH (TREATMENT AND CARE) ACT (1994) REVIEW ADVISORY COMMITTEE MEETING

MEETING MINUTES

Date: Wednesday 12 June 2013
Time: 10:15 – 12 pm
Venue: OCYFS Conference Room

Welcome	Meeting opened at 10:20am. Steve Druitt was in the Chair and welcomed RAC Members
Attendees	
Steve Druitt	Project Manager Review Mental Health Act (1994) ACT HD
Fleur Joyce	Mental Health Policy and Planning Unit, ACT Health (Secretariat)
Herb Krueger	MHJHADS
Graham Hambleton	Disability ACT
Sue Watson	Disability ACT
Keegan Lee	DPP
Glenn Thomas	ACT Policing
Anita Philips	PA
Simon Viereck	Mental Health Community Coalition
Craig Allatt	Carers ACT
Dalane Drexler	CEO, ACT Mental Health Consumer Network
Sean Costello	Human Rights Commission
Amanda Davies	Policy Officer, ACT Mental Health Consumer Network
Victor Martin	JACS
Matt Hingston	Human Rights Commission
Christina Ryan	Advocacy For Inclusion
David Lovegrove	ACTMHCN Consumer rep
Peter Norrie	MHJHADS
Jon Wood	ACT Ambulance Service

Apologies	
Ross O'Donoghue	Policy and Government Relations, HD
Richard Bromhead	Manager Mental Health Policy and Planning Unit, HD
Andrea Tokaji	JACS
Len Lambeth	MHJHADS
Tony Malone	Corrections

Coleen Sheen	CarersACT
Linda Kohlhagen	MHJHADS
John Hinchey	VOCC

Minutes of the last meeting

Notes from RAC meeting of 3 June circulated.

Actions from last meeting

No actions arising.

Actions arising from this meeting

1. Item 84 - specific drafting proposal on emergency ECT to be agreed by email between MHPU, HRC, the Chief Psychiatrist and MHCN.
2. Feedback on the draft AA provisions circulated at the meeting.
3. Item 36 – RAC members to advise position please

Discussion of recommendations

The Chair reported that items greyed out on the summary document were those that were agreed to by all 5 members who had responded prior to the meeting indicating their position and that these matters were not open for general discussion. However, the Chair invited all members look briefly at the items and raise any specific questions.

Items 1, 11, 59 and 69 were raised.

Item 1 – the importance of advising people in writing rather than just verbally was confirmed and **RAC agreed that all instances of tell should be examined for possible amendment to tell in writing.** It was acknowledged that there are instances where a reference to 'tell orally' is warranted and that there are other instances where to 'tell' is just the first step of a series that includes telling in writing.

Item 11 – while RAC members who had responded to the summary document agreed that guidance around the meaning of 'assistance' and 'all practical steps' should sit in a code of practice document rather than the Act, RAC heard argument for including these provisions in the Act given the communication barriers faced by many who are subject to the Act. **RAC agreed that the provisions should be included in the legislation**.

Item 59 – RAC noted that this provision applies to any person exercising apprehension and seasrch powers under the Act and rather than just police. **Review Team to ensure provision is applied in all relevant instances.**

Item 69 – While CarersACT accepts the advice about the Legislation Act, they would like the fact

that singular means plural drawn to the attention of clinicians. **RAC agreed that a note to this effect should be included in the Act.**

Remaining greyed items 2, 7, 10, 12, 14, 16, 40-43, 51, 56-58, 60-63, 66, 68, 70, 72-73, 76, 78-79, 82, 85-86, 90-91, 95-96 were agreed in full by RAC.

Item 84

The Chair asked that the RAC then address item 84 – ECT provisions. RAC heard that there are significant concerns about the proposed extension of the emergency ECT provisions, with a view that they are incompatible with human rights. RAC members agreed that the provisions as drafted do not reflect the intention as explained by the Chair. The Chair advised that the intention is to extend the availability of emergency ECT to people whose life is not at immediate risk but will be within the 3 day notification period. The Chief Psychiatrist advised that ACAT does not have the capacity to approve emergency ECT in such circumstances because the current wording is so precise in relation to immediate threat to life. RAC agreed that the intention is sound, that the provision of emergency ECT is reasonable in the circumstances described and that the provision should be re drafted accordingly.

ACTION ARISING 1

The Chair then asked RAC to consider the remaining items in order of the summary document.

The Review position at items 3, 6, 8, 23, 39, 44, 45, 45(a) and (b) was accepted by the RAC.

These items were discussed and amendments made.

Item 4
HRC clarified its position on the inclusion of provisions to support the new carers objects and the need to signpost the health records Act in respect of information sharing. HRC advised that these are two different areas for attention. The objects describe what the Act will do and as such provisions to support or develop each of the objects are needed. HRC suggested that the objects be moved to the principles so that they are taken as matters that must be kept in mind in exercising a function under the Act.

The principles are currently expressed as rights. **RAC agreed that the carer objects could be reworded and would fit best under 6(g).**

In addition, the need for clinicians and other users of the Act to be more conscious of the existing provisions of the Health Records (Privacy and Access) Act is acknowledged and could be served by a note in relevant places drawing attention to those provisions.

RAC agreed.

Item 5 RAC agreed that the current range of ways in which definitions are expressed is confusing and not user friendly. **RAC agreed to ask PCO to simplify the number of ways of drafting definitions in the Act.**
Item 9 The proposed amendments were rejected by RAC. **RAC agreed that the ES should address the interaction between the human rights expressed in the principles and the limitations on those rights by the provisions in the Act.**
Item 13 **RAC agreed this item is addressed by the amendment to Item 14 already agreed.**
Item 15 **RAC agreed with the submission but requested that the provision be repeated at s6 not moved from s8(1)(a)**
Item 17 JACS noted the need to rephrase 'right to legal advice' as right to *seek* legal advice' wherever the matter is addressed in the Act. **RAC agreed.**
Item 18 RAC agreed with the submission on how information must be provided and further amended the provision to replace the reference to ' a form most likely to be understood' with 'most appropriate to the person'.
Item 19 – 22 and 24-34 These items relate to the Advance Agreement provisions that are subject to ongoing discussion and work by the AA working group. Draft provisions were circulated for feedback with a new draft to be discussed at the next meeting. <u>ACTION ARISING 2</u>
Item 35 RAC noted this proposal is already covered by s35(1)(b). **NFA**
Item 36

MHPU NOTE: it is possible that discussion on this item was confused with item 50. The proposal in Item 36 is not sound. The sections referred to in the submission are about the ability of the ACAT to make an order without notification where there is a reasonable belief that notification to the subject person would give rise to an immediate and significant risk of harm to a person (the subject person or another person). These sections are not about capacity. **MHPU suggests that the proposal be rejected.** ACTION ARISING 3
Item 37 RAC discussed at length the purpose of the proposal and the circumstances in which it arises. The proposal seeks requirement for person to be advised of their rights when being attended by an assessment team. Discussion centred on the need for CATT teams attending a person to ensure the safety of the subject person and others. JACS put the view that the person does not have a right to seek legal advice at this point. **RAC agreed that a person should be told that an assessment order is not an order for treatment and that no involuntary treatment could occur without a further order for such. Also should be told that before any treatment is provided under a subsequent order the person will be advised of their rights under the Act.**
Item 38 MHPU note : the new ACAT proposal is relevant to Item 40 not Item 38. RAC agreed that the proposal for a timeframe is dealt with at Item 40. Other proposals to insert 'approved mental health' before 'facility' (and approved before mental health facility) for PCO drafting advice.
RAC agreed to meet again to discuss remaining items from item 46. next meeting – Friday 14 June at 1pm in large conference room on level 3 of 1 Moore St.

Review of the ACT Mental Health Act
Review Advisory Committee

AGENDA

Friday 14 June 2013
Level 3 Conference Room, 1 Moore Street
1pm

1 Welcome and Introductions for any new participants

2 Attendance and apologies

Participants to sign attendance sheet circulated at the meeting.

3 Minutes of last meeting

Minutes of RAC meeting 12 June circulated 13 June

4. Actions arising from last meeting.

- i Item 84 - specific drafting proposal on emergency ECT to be agreed by email between MHPU, HRC, the Chief Psychiatrist and MHCN. **Emailed 13 June, for discussion in agenda item 5a.**
- ii Feedback on the draft AA provisions circulated at the meeting. **No further feedback received OOS. For discussion at RAC – see agenda item 5c.**
- iii Item 36 – RAC members to advise position please.

5 discussion of recommendations arising from public consultation on second Exposure Draft.

a. V3 circulated after last meeting with additional items now in grey due to RAC agreement at that meeting.

b. Discussion will commence at Item 46.

c. AA provisions

NB: new items (highlighted yellow) have been inserted with the same item number as the item before them but with an (a) to keep the original items numbering intact.

6 Next Meeting

No additional meetings are scheduled. Remaining issues will be dealt with out of session.

THE ACT MENTAL HEALTH (TREATMENT AND CARE) ACT (1994) REVIEW ADVISORY COMMITTEE MEETING

MEETING MINUTES

Date: Friday 14 June 2013
Time: 10:15 – 12 pm
Venue: OCYFS Conference Room

Welcome	Meeting opened at 10:20am. Steve Druitt was in the Chair and welcomed RAC Members
Attendees	
Steve Druitt	Project Manager Review Mental Health Act (1994) ACT HD
Fleur Joyce	Mental Health Policy and Planning Unit, ACT Health (Secretariat)
Victor Martin	JACS
Andrea Tokaji	JACS
Sue Watson	Disability ACT
Keegan Lee	DPP
Glenn Thomas	ACT Policing
Simon Viereck	Mental Health Community Coalition
Craig Allatt	Carers ACT
Sean Costello	Human Rights Commission
Amanda Davies	Policy Officer, ACT Mental Health Consumer Network
Matt Hingston	Human Rights Commission
David Lovegrove	ACTMHCN Consumer rep
Peter Norrie	MHJHADS
Tony Malone	Corrections
Coleen Sheen	CarersACT
Jon Wood	ACT Ambulance Service
Renate Moore	CMTD
Nathan Boyle	CSD, OCYFS
Sam Le Page	CSD, OCYFS
Rowan Ford	CSD Strategic Policy
Linda Crebbin	ACAT

Apologies	
Ross O'Donoghue	Policy and Government Relations, HD
Richard Bromhead	Manager Mental Health Policy and Planning Unit, HD

Herb Krueger	MHJHADS
Graham Hambleton	Disability ACT
Linda Kohlhagen	MHJHADS
Dalane Drexler	CEO, ACT Mental Health Consumer Network
Christina Ryan	Advocacy For Inclusion
John Hinchey	VOCC
Megan Sparke	VOCC office
Bernadette Mitcherson	Corrections
Christine Waller	MHJHADS

Minutes of the last meeting

Notes from RAC meeting of 10 June circulated. No changes received but additional names added to apologies by meeting organiser. Amended minutes circulated Monday 17 June 2013.

Actions from last meeting

1. Item 84 - specific drafting proposal on emergency ECT to be agreed by email between MHPU, HRC, the Chief Psychiatrist and MHCN.

   RAC agreed to draft email as circulated by Steve Druitt.

2. Feedback on the draft AA provisions circulated at the meeting. CarersACT provided feedback requesting that amendments to AAs be notified to nominated people.

   RAC agreed that the working Group should continue its work and circulate final proposal to the RAC asap.

3. Item 36 – RAC members to advise position please.

   RAC agreed that these sections do need strengthening of the provisions relating to risks, to require that a person stating their belief about a risk also state their reasons and evidence for the belief.

Actions arising from this meeting

1. Sue Watson to provide further information to MHPU on chemical restraint to assist with drafting of a suitable provision.
2. JACS to seek advice from Wayne Appleby on detention of Aboriginal and Torres Strait Islander people in a CrC.
3. MHPU to check that health attorneys are not enabled to consent to psychiatric treatment under part 2A of the GMPA due to removal of psychiatric treatment from the list of proscribed treatments under that Act.
4. Ambulance ACT to provide wording for definition of a paramedic.

Discussion of recommendations

Chair reminded RAC that all greyed items were agreed in full by RAC at the last meeting and that discussion today would be confined to remaining items. This accounts for any missing item numbers from the consecutive listing. Discussion commenced at Item 46. Items 46 RAC agreed to accept PCO drafting advice
Item 47 Proposed to add to the criteria: The D-G for the Corrections Management Act & the D-G for the Crimes (Sentence Administration) Act, or for a young detainee, the D-G for the Children and Young People Act **RAC agreed**
Item 48 ACAT suggested that a consequential amendment to the Guardianship (P+A) Act should provide ACAT with power to consider a guardianship order where criteria for a PTO are not satisfied in respect of a person who does not have DMC. **RAC agreed.**
Item 49 RAC heard that this is a data collection tool that will assist at the 3 year review stage. **RAC agreed to the proposed amendment**
Item 50 RAC received the amendment to the provisions at s54 and 62 circulated by Steve Druitt and accepted that the amendment elevated DMC over risk sufficiently. **RAC agreed to the proposed amendment**
Item 52 RAC questioned whether chemical restraint is currently permitted and if not whether regulating it would in fact introduce it to the sector. Also questioned interaction with the emergencies Act although this point was satisfied in the negative by RAC members. Sue Watson to provide further information to assist with drafting of a suitable provision.

DRAFT

Action Arising 1
Item 53 **RAC agreed – PCO drafting advice**
Item 54 **RAC agreed s61(3) should be located with s61(2)(iii).**
Item 55 RAC noted the differences between the CP and the CC and that the principles and objects of the Act cover both statutory offices. JACS noted that the information sharing provisions should assist to address concerns about the CC sharing information more easily because they are not confined in the same manner as the CP in respect of client interests. **No change proposed at RAC. NFA**
Item 60(a) **RAC supported the proposed amendment.**
Item 61(a) **RAC agreed with the concern raised about the burden placed by section 81 and agreed to insert the words 'as far as practicable' in the provision**
Item 64 **RAC did not accept the proposal. NFA**
Item 65 RAC noted the brief discussion of this matter at the first meeting and did not agree with the proposal. **NFA**
Items 67 - 68 JACS proposed to the RAC that alleged offenders be removed from the forensic provisions and noted that a number of the remaining items/sections of the Mock Up which had raised significant concerns would no longer be part of the proposed revisions to the Act. They would therefore not require discussion and could be struck from the summary document. **RAC agreed to remove alleged persons from the forensic provisions and noted that these items plus items 74 and 80 are no longer required.**

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Item 68(a) **RAC agreed that the power of guardians to make decisions about psychiatric treatment should be by endorsement of individual guardianship orders.**
item 71 **RAC did not agree with the proposal. NFA**
Item 75 RAC heard that the issue of limiting terms remains an area for discussion. JACS noted that they intend to amend the forensic provisions to create a new section on detention in a CrC which will reference the Crime Act power at Part 13 and include clear reference to it being an option of last resort. In addition the power of ACAT to detain at a CrC until otherwise ordering should be time limited and consideration will be given to the steps that must be exhausted or what options must be unavailable before detention at a CrC is considered a 'last resort' option. JACS also noted that the capacity to detain young people at a CrC is the subject of a request for advice to CSD/OCYFS. RAC heard of concerns relating to detention of Aboriginal and Torres Strait Islander people from CarersACT and it was suggested that advice be sought from Wayne Appleby at UC on this matter. Action Arising 2
Item 77 **RAC agreed with the proposed amendment**
Item 81 **RAC agreed to proposed amendment**
Items 83 RAC agreed to the proposed amendment.
Item 84 RAC supported the amendment to the proposed change on PTO criteria as circulated by Steve Druitt after RAC met Wednesday 12 June.
Item 87 RAC heard that JACS would consider a 5 year review specific to detention in a CrC provisions. **RAC agreed**

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Section 88 This item is a procedural matter and is with ACAT for further advice. **NFA**
Item 89 **RAC agreed that ACAT powers in relation to arrest warrants should be explained fully in the ES.**
Item 92 **RAC agreed the concerns raised in this proposal should be addressed through a code of practice but accepted that the notions of 'expresses willingness to accept treatment' be fully explored along with who will determine that willingness is expressed.**
Item 93 RAC herd that ACAT already considers the suitability of a person before appointing them Guardian. **NFA**
Item 94 **The RAC agreed that the DMC of a person should be assessed at the time that they begin to be treated under the mental health act regardless of previous assessments.**
Item 97 RAC heard that it was not the intention of revisions to the Act that the removal of psychiatric treatment from the list of proscribed treatments under the GMPA would enable health attorneys to to consent under part 2A of that Act. **MHPU to check and advise.** Action Arising 3
Item 98 **RAC agreed to amend the definition of a paramedic in accordance with wording to be provided by the Ambulance ACT Service.** Action Arising 4
Item 99 **RAC did not support any amendment to the 6 month limitation on consent by a guardian. NFA**
Meeting closed at 3pm.

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RAC Responses to Summary of Themes

Rows in grey are agreed by responding parties and will not be generally discussed at RAC meeting 2

Rows in pink are advance agreement provisions and are replaced by the provisions developed by the AA working group, which met Thursday 6 June 2013. The new provisions are at attachment B.

Rows in pale green are agreed by responding parties with provisos from one or some.

Rows highlighted in yellow are new recommendations that require RAC consideration.

Abbreviations used in this document:

ABBREV	MEANING	ABBREV	MEANING	ABBREV	MEANING
CP	Chief Psychiatrist	PCO	Parliamentary Counsel's Office	TCS	treatment, care and support
CC	Care Coordinator	MU	Mock Up	AP	Affected Person
CCO	Community Care Order	SMHU	Secure Mental Health Unit	MHF	mental health facility
FCCO	Forensic Community Care Order	PoA	Power of Attorney	CrC	correctional Centre
MHO	Mental Health Order	TT	Treating Team	HR(P+A)	Health Records (privacy and access) Act
FMHO	Forensic Mental Health Order	HRC	Human Rights Commission		
PTO	Psychiatric Treatment Order	HRA	Human Rights Act		
FPTO	Forensic Psychiatric Treatment Order	HRdA	Health Records Act		

There were 12 submissions and a number of consultation meetings with stakeholders.

Broad issues

Submissions raised issues about several broad areas:

1. Belief that there are examples of unwieldy drafting leading to ambiguous or confusing provisions.

2. View that several terms require definition or current definitions need to be clarified.

    a. Community care facilities not managed by the Territory are not covered in the Act leaving out a significant number of people who would otherwise be subject to the provisions of the Act. There is an imbalance between treatment and care, which would be more relevant to people with mental health disorders.
    b. The imbalance between the needs of people with MI and MD results in a one sided consideration of restraint. Restraint mechanisms are required to keep people safe in, for example, nursing homes or aged care facilities and may be refused even where the person has DMC to consent. However, in the case of secure accommodation, a method of restraint is applied without sufficient assessment of the person's DMC.

3. Concern about the rights of people who would now be treated under the guardianship and management of property Act and about the interaction of the MHA and the GMPA generally. There has been a strong recommendation by the RAC that the GMPA be reviewed, partly due to these concerns

4. Belief that proposed provisions for consumer determined treatment should be strengthened.

5. A view that further amendment supporting carers' ongoing role in the care, treatment and support of consumers is necessary and compatible with human rights legislation. The principles around working collaboratively with carers are intended to overcome a difficulty identified by legal advice that compelling clinicians to share information with carers would have unintended negative consequences, and would not be acceptable from a human rights viewpoint. That is, there would be occasional instances where the clinician was obliged to share information when they could see that it was not in the person's best interest. The Health Records Act currently ALLOWS sharing of information where the person does not have capacity, but does not compel, giving the clinician discretion. If the person has capacity they make their own decision about who shares information. It is therefore felt that this matter is more flexibly dealt with at a policy and protocol level, and by education. The legal advice regarding this matter has been confirmed

HRC Comment - HRC isn't sure we've ever put the human rights aspects of this issue in a definitive way. Part of this is a culture change necessary amongst clinicians. The Health Records Act is all too often cited as a reason not to talk with families and carers when the Act would allow them to do so. The right to privacy is not absolute, and can be limited where such limitation is proportionate. If the Health Records Act is already accepted as a proportionate limitation on the right to privacy, then ensuring that the new Mental Health Act recognises existing rights of carers and families would not appear to limit it any further?

6. Broad concern about several elements of the forensic provisions, particularly power of ACAT to detain a person in a CrC and extending to a future SMHU in the case of people under 18. The HRC's view is that this power invokes several sections of the HRA and only charged people should be held at a CrC, including young people at Bimberi. This concern extends to the SMHU and it is considered that a stand alone MH facility for young people in the justice system is required. **Consider noting in the MHA that people under 18 cannot be detained in any CrC or adult SMHU** Victor
7. Concern that ACAT and justice bodies (sentencing board) do not share information and that a person may breach parole conditions because they are detained at a MHF (Crebbin in consultation mtng 17/5/13)
8. Affected Persons (AP) Register and entitlement of AP to information once subject person is no longer subject to a FMHO
9. Particular concerns about the lack of detailed information in the Act about
    a. AA provisions to be expanded in Explanatory Statement
    b. DMC assessment processes including standards. Province of a code of practice
    c. who may prepare reports to ACAT? At present a psychiatrist
    d. Treatment and Care Plan standards – these will vary with the stage of assessment
    e. The current HD policy directive that patients must be reviewed every 2 weeks and every three months by a psychiatrist. Policy level
10. Concern among clinicians that AAs will lock them into unmanageable requests where the AA was made with another clinician and would also be an unreasonable workload to get agreement of all parties. Subsequent concern from others those clinicians will discourage, or at least may fail to encourage consumers to consider making an AA. The new human rights environment entitles people who have capacity to make their own treatment decision. AAs are an extension of this right, and clinicians can therefore be reasonably expected to support their development. It is a

service matter to ensure that AAs are of a suitable standard. AAs support engagement in treatment planning and voluntary treatment and from this perspective support the work of clinicians.

11. A plain English code of practice and best practice guidelines should be produced to detail:

    a. when giving medication is regarded as chemical restraint; agreed
    b. the primacy of and criterion for DMC including the spectrum of decision making capacity and assistance; will be included in Explanatory Statement. A code of practice and training are also envisaged
    c. inclusive practices and examples of engagement of families and carers in treatment and care of people with a mental illness. (MHCC) Agreed. Would collaborative development of service protocols be more effective?

Specific recommendations

Many Submissions made suggestions for specific drafting amendments and others noted particular sections requiring further thought/amendment:

	mock up reference	**recommended amendment**	**source of rec'dation**	**Review Team comment or support**	**RAC member agreement or comment or question**
1.	*Through-out the Act*	replace tell with tell in writing	**MHCC**	*RAC agreement supported*	*RAC agreed to check for missed instances where it should be 'tell in writing'*
2.					dealt with at item 5
3.	*through-out the Act*	Use gender-neutral terms rather than he or she. There are several instances of the latter remaining in the Act. (MHCC)		*Suggested to drafters*	
4.	*section 5*	That provisions be introduced to the Act to support objects (g), (h) and (i) by requiring that clinicians	**(HRC)**	*RAC agreement*	RAC agreed to move the carers objects to principles (g) and

		consider the views of families and carers.		*supported*	express accordingly. RAC agreed to include a note signposting the provisions in HR(P+A)Act in relevant place(s) Further work at protocol level and education to stakeholders will be required
5.	*Definitions throughout the Act*	Definitions within the body of the act should have a consistent position and drafting approach. 2 places – the dictionary at the back and a consistent location for those within the body is enough for any reader to manage. Current approach with definitions in body at the start of a chapter, or end of a section or within paras very user unfriendly.	**several submissions**	*RAC agreement supported*	RAC agreed to ask PCO to consider simplifying the number of ways definitions are expressed.
6.	*section 5(i)*	Amend to add orange text: Promote inclusive practices in treatment, care and support to engage families and carers in responding to an individual's mental; disorder or mental illness and to facilitate the involvement of families and carers in decisions about appropriate care, treatment and support in partnership with medical professionals.	**Carers ACT**	*supported but with necessary amendment to now fit this object into the principles (g) section.*	RAC agreed to include the amendment. note to drafters - care and treatment should be reversed for consistency with rest of Act.

7.	*section 5*	Include *recovery* in the objects	**MHJHADS**	*supported*	
8.	*section 6*	amend principle 3 (recovery) to include that: *while a decision may be made in a person's best interests it is also required that that the person's will and preferences – to the extent that they are known and are able to be determined- are taken into account in that decision.* A person with a mental disorder or mental illness has the right to have their will and preferences – to the extent that they are known or are able to be determined- taken into account in any decision made in their best interests about their treatment, care and support. (MHCN)	**ADACAS**	*RAC agreement supported*	RAC agreed
9.	*section 6*	(b) add *unless subject to involuntary conditions* (d) remove *best*	**MHJHADS**	*Proposed amendments are not supported.* *ES will include explanation as agreed by RAC.*	RAC did not support the proposed amendments but agreed that the ES should include explain that the principles set out the persons human rights which should always be considered and only limited when necessary under the provisions of the Act
10.	*section 7*	insert new (a) *understand whether a decision needs to be made*	**ADACAS**	*supported*	question for MHPU - should it be 'that' rather than 'whether' a

		insert new step before current (e) *on the basis of (a) – (e) make a decision…*			decision needs to be made?
11.	*sections* *7 and 8*	Guidance is required on the meaning of "assistance" and "all practicable steps" in sections 7 & 8. Suggests including the following guidance. *a. The best efforts must be made to provide information in a manner that the person can understand, including through alternative formats. For example, photos, visual aids, Easy English documents, Auslan etc.* *b. The best efforts must be made to support the person to communicate about the decision in a way that is appropriate to them. This includes via alternative communication formats such as those above.* *c. All means of support should be provided in order to help the person make and communicate a decision. This includes the use of existing support networks and independent advocacy.* d. *These steps should be undertaken for every decision.*	**Advocacy for Inclusion**	*RAC position supported.* *PCO to draft.*	*RAC accepted that these points are sufficiently important to include in the body of the Act and agreed that provisions should be drafted*
12.	*section 8*	insert provision to recognise DMC fluctuates and may be present in particular decisions, times and	**ADACAS**	*supported*	

		circumstances and not at others.			
13.	*Section 8*	DMC definition does not accord with the principles of the UNCRPD	**ADACAS)**	*see comment below at item 14*	*RAC agreed that this matter is addressed by amendment to s8(1)(b) below*
14.	*8(1)(b)*	should state "a person who has impaired decision-making capacity must always be supported to make decisions about his or her treatment, care or support to the best of the person's ability" instead of "contribute to".	**Advocacy for Inclusion**	*RAC agreement supported*	RAC agreed to the amendment
15.	*section 8(1)(a)*	The principle that a person must be assumed to have decision making capacity only applies, on the face of it, when an individual's decision making capacity is being specifically considered. This is the result of including the assumption of capacity in principles that apply to consideration of capacity. This is a circular approach, which undermines the importance of the assumption of capacity. *Recommendation:* move paragraph 8(1)(a) into section 6, so that it is clearly a principle that applies in every case when a person is exercising a function under the Act.	**ACTMHCN**	*RAC agreement supported*	RAC agreed to replicate 8(1)(a) at section 6.
16.	*section 8*	amendment to specify that the presence of a guardianship order does not permit a conclusion to be drawn about the person's DMC when considering a mental health matter	**HRC**	*supported*	
17.	*section 14(b)(ii)*	Reinstate right to legal advice and a second opinion, which have been removed since the first exposure draft.	**MHCC**	*RAC position supported.*	RAC did not take a position on whether these rights should be

					mentioned as examples in this provision but agreed that both rights should be included in the statement of rights. RAC noted that the right is to SEEK legal advice rather than legal advice per se.
18.	*Section 14 (2) and (3)*	Replace both sections with: *The responsible person shall ensure that a person is given an information statement and that the information contained in the statement is conveyed to the person in the language, ~~form or~~ mode of communication or terms appropriate to the person .*	**MHCC**	*Proposed amendment as amended supported*	RAC agreed with the amended proposal and further amended it by changing *"...that the person ismost likely to understand.' to "...appropriate to the person"*
19.	*section 19*	Define the TT and specify what role the consumer has in choosing their TT and how the TT Representative is determined. include GPs in the TT	**MHCC** **MHJHADS**	*The person makes an AA when they have capacity, and so Treating Team is the health professional/s of the persons choice. If the person seeks treatment from the government service when they have capacity, then the Team could either agree to treat according to the AA or offer the treatment they feel is appropriate which the person could accept or refuse. If they are involuntary and the the Team wishes to treat them*	N/a (see separate AA paper)

				for say, schizophrenia rather than the adult attention deficit disorder set out in the AA, they would apply to the ACAT. My understanding is that it would be up to the Treating Team to nominate a representative. In the best circumstances this would be done in consultation with the person.	
20.	*Part 3.3*	specify that an AA does not enliven any power to restrain, detain or apprehend a person even if such actions are considered necessary to give effect to an AA provision.	**HRC**	*supported*	N/a (see separate AA paper)
21.	*Part 3.3*	there is currently no provision to describe interaction between an AA and emergency actions. *Recommendation:* That an AA is suspended where an emergency detention takes place for the period allowed under emergency detention (14 days)	**HRC**	*not supported fully.* *case by case basis, specific provisions to be considered.*	N/a (see separate AA paper)
22.	*Part 3.3*	A person should have their nominated person or another support person with them while developing an AA with members of the treating team who will be party to the AA.	**ADACAS**	*Supported*	N/a (see separate AA paper)
23.	*Section 18*	**The term Nominated person could be confused with 'nominees' under the federal NDIS legislation**	**edeson**	*RAC position supported*	**RAC did not support changing the term, 'nominated person'.**

24.	*section 18*	There is no consideration of the possibility that a nominated person may benefit from being the nominated person and whether this should be so	**MHJHADS**	*The Nominated Person does not have any decision making power about treatment. It is a way the person can identify who best knows their wishes, history etc, and who can express their preference for treatment when they may not be able to speak for themselves. This can be useful for clinicians when for example there is disagreement among relatives. If the clinician thinks the person is not representing the person's best interest, the clinician would need to take that into account.*	*these AA provisions are replaced with new drafting proposed by the AA working group at Attachment B.*
25.	*sections 20 and 21*	<u>Three suggestions for amendment to section 21 received.</u> Issues are that: 1. s.20(1) only provides for an AA to set out a person's 'preferences' and s.21, refers to a person's wishes rather than consent in relation to treatment. The section refers to consent only in relation to seeking views from family members or carers (paragraph 21(d)). The AA should be able to set out preferences and wishes as well as	**ACTMHCN** **MHCC** **Carers** **HRC**		

		specifying consent and lack of consent. The AA Working Group agreed that an order would only be required to override or not actively comply with an AA direction about a significant clinical treatment matter. Other non-compliance with AA provisions would require suitable documentation of reasons. S21 requires amendment to work appropriately with s26. Treatment directions should be dealt with separately from care and support directions to clarify where an order is required and where it is not. (HRC) *Recommendation 1:* Amend s21 to say *a. the ways in which the person consents to be treated or cared for; and* *b. the ways in which the person does not consent to be treated or cared for, including specific medications the person does not consent to* *Recommendation 2:* Replace 21 with: *An advance agreement for a person may include the following:* *(a) The ways in which the person wishes and/or does not wish to be medically treated in relation to the person's mental disorder or mental illness;* *(b) The ways in which the person wishes and/or does not wish to be cared for and supported in relation to the*	**all raised issues about this section**	*supported but with additional provision – any other matter the person wishes to include that is relevant to their TCS.* *also support separation of matters requiring an order and those requiring a statement.*	

		person's mental disorder or mental illness; *(c) The ways in which the person wishes information to be shared, or not shared.* *Recommendation 3* add 21(e) to say: *Whether and to what extent the person consents to information sharing with family members or carers in relation to treatment, care or support of the person's mental dysfunction or mental illness.*			
26.	*section 22*	Duration of AAs the ability to continue treatment under s.27 after the AA has ended at the end of 12 months is unlimited, so that as long as the person does not actively object to the treatment it could continue indefinitely. Recommendation: limit treatment in accordance with AA to a period not more than six months more beyond the 12 month duration of an AA no longer in force under s.22.	**ACTMHCN**	*not supported* *This recommendation is inconsistent with a recommendation arising out of consultation discussions that AAs should remain in force until the person makes the decision to end the AA. Their AA should not lose status during a period of incapacity. Where a treatment decision that is inconsistent with the AA is clinically required, the treating team applies to ACAT for an order to override the AA meaning*	

				that the ACAT has oversight of decisions that do not accord with the person's last expressed wish.	
27.	*s24*	S24 should not allow an AA to be ended verbally. Ending an AA should be as formal as starting one.	**ADACAS**	*Not supported.* *This equates to a right in broader health to end an advance directive verbally ACT Medical Treatment (Health Directions) Act2006, S.10*	
28.	*Section 26*	extend 26(3) to indicate 26(2) does not apply if non compliance relates to s21 (b) or (c) as proposed by HRC amendment to section 21 above.	**HRC**	*not supported. Unecessary. Treatment must occur in accordance with AA unless a MHO is made.* *(intend change to disallow guardian or PofA to override AA)*	HRC comment - our feedback was aimed at matters in an AA that would not be contained in a Mental Health Order (eg non-treatment matters0
29.	*section 24*	In dementia, a person's decisions may be disregarded after a year because of the 1 year limit. However, they may not be able to 'undo' a decision if it is made by a representative they nominated initially but have come to distrust.	**Edeson**	*Advice being sought on how this situation is managed in aged care*	

30.	*section 25*	is confusing and ambiguous. It appears to be inconsistent with s26 because s25 suggests AA must be considered where s26 says treatment must be in acordrance with AA.	**consultation nurse consultants**	*supported. S25 is unnecessary and will be deleted.*	
31.	*section 26*	(2) delete: *only*	**MHJHADS**	*not supported.*	
32.	*section 27*	details the process for how a treating team should act at the end of an AA. It includes that certain instruments may prevent further action under the concluded AA, including a guardianship order or power of attorney, but is silent in relation to mental health orders. Recommendation: Include note to refer to TT actions at cessation of an AA in relation to MHOs.	**HRC**	*not supported. Amendment 17 and 18 will remove need for this amendment.*	
33.	*Section 29*	Two submissions raised issues with the capacity of entities other than the ACAT being able to override AAs. Issues: 1. Overriding an AA by a guardian should remain a matter for the ACAT to consider. 2. The provisions as they stand may be an overreach of the powers when read in conjunction with s8 (equality) and s10(2) (consent to medical treatment) of the HRA. 3. In the case of attorneys, only an attorney appointed after the AA was made should be able to override it. 4. It is not sufficient for the guardian simply to take		*agree* *agree* *agree*	

		an AA into account, and record reasons for departing from it as required under Section 29. 5. A guardianship appointment should not be made without consideration of the terms of any AA, and an appointment inconsistent with the AA should only be made in exceptional circumstances. Also a question about what if any role guardians would have in AAs (ADACAS) *Recommendation 1:* Provide that where entering an AA is the most recent action taken by a person, it should prevail over a POA appointment. Provide that guardians are bound by an AA that is in effect, so that they cannot consent to treatment inconsistent with the AA. Amend the GMPA to ensure the terms of an AA are considered upon appointing a guardian *Recommendation 2* AAs made are a recorded expression of a person's will when the person has capacity and should not be overridden by a personal substitute decision maker.	**ACTMHCN** **HRC**	*agree* *a guardian wishing to override the AA would need to go to the ACAT* *agree – latest expression of the persons capacitous decision* *agree seeking advice* *agree*	
34.	*Section 29*	Remove the power for a guardian or attorney to make decisions on behalf of a person that are inconsistent with their advanced agreement.	**Advocacy for Inclusion**	*supported* *see amendments 17, 18, 20 and 21.*	N/a (see separate AA paper)
35.	*Section*	Detail is needed on the requirements surrounding	**Shuhyta**	*RAC position*	RAC agreed that this is covered

	30	assessments. Who may undertake it?		*supported*	by s.35 – particularly s.35(1)(b)
36.	*sections 32, 48 and 91 for eg.*	Include at all instances in the act where risk may override capacity, the requirement for the person concluding that risk does override DMC in the particular instance, a statement about the risks, the evidence and the reasons for their belief. Examples of where this would occur are ss 32, 48 and 91 of the Mock Up (MU). Also require ACAT to consider and judge the evidence for risk to at least a standard equivalent to "on the balance of probabilities" (MHCC) Particularly important for FMHOs as ACAT has power to detain people at a CrC (s98)	**MHCC**		NOTE to RAC from MHPU Sections 32 and 91 (Section 48 will be deleted) are examples of places in the act where there is reasonable belief that anything to do with an application for an order (assessment or treatment) carries high risk of harm to the person or another person and allows the ACAT to proceed without notification. (For example if the person is likely to seriously harm the applicant or themselves in response to hearing of the application.) They are not essentially about risk overriding capacity. The ACAT requires this information in order to consider whether to suspend notification of an assessment order or hearing This proposed amendment is more relevant to s54 at item 48.

					(Please advise if you disagree)
37.	*chapter 4*	Assessment Teams should advise people they are attending that they have the right to legal advice and a support person when the CATT is communicating with them. These rights are currently only expressed for a person at a facility.	**ADACAS**	*RAC position supported.*	*RAC agreed that can be no right to legal advice at the point that a person is engaging with the CATT as it would delay assessment and the CATT team's priority is ensuring safety of the person.* *RAC noted that the ACAT notification form will include the advice that a person has the right to seek legal advice.* *RAC agreed that a person should be informed that the order is an order for assessment only, that no treatment can be given on the order and that before any order for treatment can be implemented the person has a right to seek legal advice.*
38.	*section 35*	(a) include a time frame (1) (b) and (c) change *the* mental health facility to *a* mental health facility (d)(i) insert approved mental health before *Facility*	**MHJHADS**	*(a) is covered by item 40.* *1 b+c for PCO drafting advice* *supported d(i)*	Some confusion about this item. Newly proposed ACAT amendment moved to item 40. Remainder for consideration possibly still. 1(b) and (c), and (d)(i) are all

					drafting issues. But the references to a facility have to be read together. (b) is identifying the 'approved mental health facility' where the assessment is to be conducted. (c) refers to that same facility, so should be 'the' and NOT 'a' as this would open it up to any facility, despite (b). And if 'approved' is inserted in (b) it's not necessary in (d).
39.	*section 36*	What is the PA obliged to do with the information about an assessment order?	**ADACAS**	*PA office can advise*	*PA advised that the PA office would act on the information as appropriate giving consideration to the need for advocacy.*
40.	*section 37*	2 opposing views put: 1. 7 days for an assessment order is unlikely to be met 2. 7 days is too long for an assessment to occur if deprived of liberty ACAT suggest new provisions to tie down the assessment appointment but retain some flexibility in cases where the person is unable to, or does not, attend the appointment:	**MHJHADS** **ADACAS**	*RAC position supported*	RAC agreed that s 37 as it stands addresses all timeframe issues for assessments, given that the date time and place of assessment are set out in the assessment order (enabling ACAT to know whether the assessment order has been complied with).

		1. directs subject person to attend the MHF at the time, date and place specified. the assessment must take place within 3 days (or extended to 7 days) from the time stated in the order.			
41.	*section 38*	(2)(a) this provision is not needed. (3)(b) and (4)(b) insert *approved* before mental health	**MHJHADS**	*not supported - 2a* *supported 3b and 4b*	Agree – (2)(a) should be retained 3(b) and 4(b) agree
42.	*section 38*	Removal Orders indicate only police may apprehend but other sections extend powers of apprehension to others.	**Shuhyta**	*no change. A removal order is used where a person has failed to comply with an assessment order*	
43.	*section 39(3)(b)*	There is inconsistency in drafting provisions relating to use of force. S 39(3)(b) uses minimum force necessary whereas ss 69, 73, 75, 103, 110, and 118 simply refer to power to use force with no reference to the minimum...necessary. (HRC)		*suppport inclusion of minimum necessary with 'force'*	
44.	*section 40(2), 41(3) and 42(3)*	insert *approved* before mental health	**MHJHADS**	*RAC agreement supported*	RAC agreed and noted need for same at 40(1)
45.	*section*	(2) insert *is deemed* before practicable		*RAC position*	RAC did not support this

	41			*supported*	proposal.
45(a)	*s43.2*	insert after as soon as practicable, "...and no later than 7 days..."	**ACAT**	*RAC position supported*	RAC agreed
45(b)	*s49.3*	impermissibly binds the ACAT and needs to be deleted.	**ACAT**	*RAC agreement supported.*	RAC agreed
46.	*section 51*	remove etc. From the title.	**MHCC**	*PCO drafting advice*	
47.	*section 52*	does not currently take account of affected people, care coordinator or parole officer	**MHJHADS**	*not supported in full. This is in the current act.* *Will amend to add 51(g) to include a person with supervisory responsibility for the subject person eg parole officer*	Q – how broad will 'supervisory responsibility' be? Should be limited to corrections context.
48.					see item 50 below
49.	*section 54*	Explicitly require the ACAT to record when it has elected to make a PTO against the wishes of a person with DMC.	**HRC**	*supported*	
50.	*Sections 54 (PTO) and 62*	do not sufficiently reflect principle that DMC is a threshold criterion for orders and may be overridden	**MHCC and HRC**	*Supported. See attachment A, proposed new drafting*	RAC agreed at meeting 1 to the new drafting proposal for this section as amended - see

	(CCO)	only in exceptional circumstances.	**and others**	*of section*	attachment A with additional text in red. HRC comment - Still not sure if the proposed amendment elevates capacity above risk, if that is the intention?
51.	*Section 58*	add the consumer to the list of people to receive a copy of a determination	**MHJHADS**	*supported*	
52.	*section 61 and similar sections in FMHO*	More detailed regulation of restraint would be welcome and inclusion of chemical restraint necessary.		*supported in principle with suitable definition*	CarersACT question will this limit future developments? MHCC agrees and note TAS provisions may provide material for consideration. MHCN agrees
53.	*section 61(2)*	provide definitions of relevant place, authorised person and forcible giving of medication	**MHCC**	*PCO drafting advice*	MHCN agree with greater clarity (terms are already defined but clumsily) MHCC note preference for consistency and for definitions to be clear rather than implied from the text.
54.	*section 61(3)*	This sub section relates to section 61 (2) (iii) and should be located with it.	**MHCC**	*supported*	Disagree, as would interrupt the flow of – but a matter for drafters

55.	*part 5.5*	There is no therapeutic duty of care in CCOs or restriction orders as there is in PTOs.	**(Legal Aid)**	*further advice sought.*	
56.	*73(4)*	The requirement for 72 hours notice at section is too long	**MHCC**	*Agree. Propose change to 12 hours which aligns with obligation to inform ACAT in Section 42.2 of current Act*	
57.	*Chapter 6*	The provision requiring review of the maximum period of emergency detention and reporting to the Legislative Assembly does not appear to have been included in the 2nd Exposure Draft. ACTMHCN does not support the extended period unless there is a legislative requirement for it to be reviewed no later than 18 months after its commencement and the report made public. *Recommendation:* re-insert legislative requirement for review after 18 months of operation.	**ACTMHCN** **and MHCC**	*supported.* *its exclusion from the second exposure draft is inadvertent.*	
58.	*Section 75*	The term "commit" suicide often lends itself to negative stigma of people with mental illness who have an urge to suicide as the word "commit" connotes an act of committing a crime or committing an offense, it also implies a rational thinking process that enables a person to "commit" to something whereas an act of suicide is a result of mental illness	**Shuhyta**	*supported.*	

		or mental disorder.amend reference to commit suicide. *Recommendation:* Change wording of section to delete commit.			
59.	*Section 75(c)*	– police should include reasons for frisk search in their statement of actions taken.		*JaCS suggest that this is an operational matter for ACT Policing internally and should be resolved as a matter of training and should be further qualified within their operational manuals etc*	note for MHPU - see s.78, assuming this should cross refer to s.75, not s.37
60.	*section 79*	(5) insert unless subject to the provision of 82(b)(ii)	**MHJHADS**	*not supported. 82(b)(ii) deals with people after examination. S79 deals with non-examination. Will amend to address this need.*	
60(a)	*section 80(2)*	amend to, "if the CP believes on reasonable grounds that the person continues to meet the criteria set out in s80(1)	**ACAT**	*support*	

61.	section 81	the examination should be specified so that a physical examination is undertaken by a doctor and a psychiatric examination by a consultant psychiatrist	MHJHADS	*not supported.*	
61(a)	section 81	this could be burdensome if the person is uncooperative	ACAT	*supported*	
62.	section 85	amend section to delete detainee from (b) and (c) and insert detained person in (c) amend intro line accordingly.	MHJHADS	*supported*	
63.	Chapter 7	Terminology used to refer to those in contact with the criminal justice system should be consistent with terms used in the courts. The term 'alleged offender' is not used elsewhere in criminal proceedings in the ACT. Where no charge has been laid it is inappropriate as no formal allegation has been made. Where a charge has been laid, it is prejudicial and one of the terms used in the Magistrates Court ('defendant') or Supreme Court ('accused') should be preferred. Recommendation: Replace terms 'alleged offender' with 'suspect' where the person has not been charged with an offence and 'defendant' or 'accused person' where the person has been charged.	Legal aid	*Supported. Being revised*	
64.	Chapter 7	View that DMC should be included in FMHOs as DMC is a spectrum and all persons will have some capacity to make or contribute to decisions about	MHCC and others)	*This matter was raised as an issue in the initial stages of the consultation, and was*	

		their TCS.		*resolved in the negative*	
65.	*Chapter 7*	Requirement that mental health professionals assess risk of future harm raises concerns in several submissions due to unreliability of tools used to predict future behaviour.	**Legal Aid and MHCC)**	*Not supported.*	MHCN - Don't understand what you are proposing be changed or not changed MHCC – this is a concern only where the consequence of assessment may be preventative detention. Point is that the applicant be required to argue the case to satisfaction of ACAT, not just say that he/she reckons there is a risk
66.	*chapter 7*	The terms used for a person subject to a forensic mental health order application (presumably the respondent to the application) are not consistent. In s 95(1) the respondent is referred to as 'the person', except for s 95(1)(n) where they are referred to as 'the offender' and s 95(1)(q) where the term 'the subject person' is used. The subject person will only ever be the respondent to an application for a Forensic Mental Health Order. Recommendation: use one of the terms – 'the respondent' or 'the subject person' consistently.	**Legal Aid**	*supported. JACS to revise*	

67.	*Section 89.1*	The 'beliefs' listed in s 89(1) are those listed in s 13 of the current Act which relates to beliefs formed on reasonable grounds by a member of the AFP or the DPP in the context of what appears to be a diversionary referral to ACAT. It is inappropriate that the chief psychiatrist or a community care coordinator be required to form a view as to the appropriateness of a prosecution (s 89(1)(c)), particularly in a non-diversionary context. Unclear whether the relevant person's belief has any effect on the prosecution itself. Noting the problems with risk assessment and prediction detailed below, it is also inappropriate that the chief psychiatrist or a community care coordinator form a view about the endangerment of public safety without further guidance. 'public safety' and 'seriously endanger' are ambiguous concepts not defined in the Act. Where there is a belief the person has previously 'endangered' public safety, it is unclear whether this is limited to conduct resulting in a finding of criminal guilt or whether charged acts not yet resolved or uncharged acts may also be considered. No timeframe is given for when the past acts may have occurred. The level and type of risk (whether qualitative or quantitative) required for 'serious' endangerment is similarly ambiguous. This type of risk assessment may call for expertise in assessment of criminogenic factors that are outside the scope of expertise for mental health experts.	**Legal Aid and others**	*supported* *s89(1)(c) to be removed*	MHCN agrees. CarersACT agrees MHCC - discussion required on action on concerns regarding definition of concepts of Public Safety and Seriously endanger – needs to be defined and may be outside expertise of MH professionals to judge

		Recommendation: if s 89 is to be retained (see below), re-draft s 89(1) to exclude s 89(1)(c) and re-consider the appropriateness of 89(1)(b).			
68.	*section 90 (3)*	replace *alleged offender* with *subject person*	**MHJHADS**	*supported*	
68(a)	*section 91(1)(c) and 104(1)(c)*	there could be some plenary guardianship orders remaining whent he Act comes in although these are being reviewed as time permits. may need an provision that exisiting orders need an endorsement to apply in MH.	**ACAT**		
69.	*section 93(e)*	In some cases a carer or family member will have responsibility for providing aspects of the treatment care and support proposed to be ordered. For this reason we recommend an amendment to subsection 93 (e) to ensure that the consultation process may involve more than one person Recommendation: amend '*person*' to *persons*.	**Carers ACT**	*not supported* *S145 of the Legislation Act confers plural meaning on the singular.*	CarersACT noted agreement with the submission. MHPU position stands.
70.	*section 95*	A forensic mental health order can be made in relation to an approved mental health facility, which could include facilities managed both by the Health and Justice Directorates. It is unclear why the only Director-General referred in s.95(5) is the JACS DG. We would suggest that either both DGs should be consulted, or as in the Children and Young People's	**HRC** **MHJHADS**	*supported* C&YPAct approach	

		Act, the Director-General responsible for the *specific facility* is responsible for providing the relevant certificate.			
71.	*S95(q)*	it is not appropriate to oblige the ACAT to consider the views of the VOC in the therapeutic sphere. Should be discretionary	**ADACAS**	*Seeking advice*	
72.	*section 96*	provide explicitly that the ACAT cannot order a particular treatment	**MHJHADS**	*supported*	Agree – also applies to s.53
73.	*Sections 97 and 104*	The criteria in proposed s 97(2)(c) includes consideration of past 'endangerment', whereas that criteria is not included in s 104(2)(c). Recommendation: make these sections consistent.	**Legal Aid**	*S104(3) covers this.* *Will ask drafters if this can be made clearer*	
74.	*Sections 97 and 104*	s 89 purports to confer an ability to apply for a forensic mental health order in relation to 'alleged offenders'. However, proposed ss 97 and 104 do not vest ACAT with a power to make orders in relation to that class of persons. Sections 97 and 104 are limited to 'detainees' (which includes a sub-set of 'alleged offenders'), those serving a 'community based sentence' and those referred to ACAT following a finding of unfitness to plead (a further sub-set of 'alleged offenders'). No reference is made to persons found not guilty by reason of mental impairment. If the inconsistency is resolved by extending ACAT's	**Legal Aid and others**	*supported* *this inconsistency and that at ss 97 and 104 also picked up by review team and will be amended to include those currently called 'alleged offender'*	MHCC – Agree. Inconsistency should be resolved and accept resolving by encompassing Alleged Offenders Agree to reserve power to detain in correctional facility to specific subsets of alleged offender category. Discuss whom to be included in this.

		jurisdiction to encompass 'alleged offenders', we would submit that it is inappropriate for an 'alleged offender' to be detained by ACAT in a correctional centre under any circumstances. Recommendation: Remove power of ACAT to detain a person at a correctional facility.		*supported in respect of 'alleged offenders'*	MHCN Agree (subject to next rec) CarersACT agrees.
75.	*sections 98, 102, 105, 109, 113(2) and 114 together*	s98(1)(e) gives ACAT power to detain a person at an approved mental health facility or a correctional centre. S 102 provides a mechanism to review detention, implying that the person may be detained on the force of the ACAT order alone. S105(1)(f) gives ACAT power to detain a person at an approved community care facility and s109 appears to operate similarly to s 102. Further, s114 appears to assume detention would be possible on force of an ACAT order alone. These sections appear to be incompatible with s 113(2), which provides that all forensic mental health orders cease when the person stops being a 'detainee' or their community based sentence comes to an end. This would appear to give primacy to court orders for detention and release. The position regarding those who have been found unfit to plead is unclear. If ACAT's jurisdiction were extended to cover 'alleged offenders', and a person were charged and bailed either by police or the court to appear at court on a particular day, but subsequently detained by ACAT in a correctional centre, the person may be put in breach	**Legal Aid**	*supported.* *provisions for ACAT to order detention at a Corrections Centre will be limited to circumstances permitted under Part 13 of the Crimes Act.*	Agreed by MHCN Agreed CarersACT. MHCC agrees but further discussion needed to ensure the actual issue is covered – intersection between detention ordered by ACAT/duration of FMHO and duration of period in which the person is a detainee or serving a community-based sentence HRC notes - may still be a broader question in terms of any detention in a correctional centre for the purposes of MH care. Constitutional questions aside, seems to be some key principles: 1) For ACAT to make a FMHO, it

		of their bail. If the Court is unaware that ACAT has made an order, then no warrant for production would be issued and presumably a warrant may be issued for the person's arrest due to non-appearance.			must address the mental illness through treatment in the least restrictive way that goes to the risk of harm; 2) That treatment must be humane Will detention in AMC ever meet those requirements?
76.	*section 111*	The 7 day requirement is impracticable. Could it be dealt with in a restriction order? NB: Typo - (7) should be (6)	**MHJHADS**	*not supported* *There are no restriction orders withFMHOs. Restriction provisions may be included in the FMHO. The FMHO may indicate that (1) restrictions on communications are permitted AND (2) that a person must not approach a person/place or undertaken an activity. The first requires the 7-day rule, the latter would*	

				not.	
77.	*section 118*	7(b) should be consistent with (a)	**MHJHADS**	*JACS seeking advice from CSD*	*?*
78.	*119*	remove reference to CrC Define abscond	**MHJHADS**	*supported* *not supported. Ordinary dictionary meaning.*	
79.	*S121 –*	a person should be able to provide new information to the ACAT if they consider they no longer require an order.	**ADACAS**	*supported. Intention to provide mechanism for subject person to seek review of the order, ACAT to have discretion.*	question - same position should apply to all orders?
80.	*part 7.3*	Some concern that aligning the definition of affected person with a VOC expands the number of people on the register and a view that it is not desirable to mandate the list of matters that must always be disclosed.	**MHCC**	*not supported*	MHCN agrees. MHCC agrees with sufficient safeguards in place. CarersACT unsure.
81.	*section 131*	add correctional centre	**MHJHADS**	*supported in part*	MHCN agrees (assuming reference is to (2)(e))
82.	*Section 141*	requires 72 hrs notice and is discriminatory in the case of some faiths where the person needs leave to	**Edeson**	*Supported in principle* *JACS reviewing to*	

		attend a funeral as they must happen within 24 hours. ()		*resolve leave provisions generally*	
83.	*section 158*	add *or another person*	**MHJHADS**	*supported*	
84.	*section 158*	proposed extension to ECT emergency provisions at s158 are incompatible with the HRA. Similar proposals (tighter) were rejected in 2005 on this basis. (HRC)	**HRC**	*For discussion*	
85.	*Part 7.3*	include requirement for affected people to be informed of the confidentiality of the information they receive as an affected person and their obligations not to disclose it publically.	**VOCC**	*supported with provision for exclusion from register and criminal sanctions in respect of young people subject to an order.*	
86.	*Chapter 8*	There is no provision for a corrections patient to consent. *Recommendation:* explicitly state that the same rules for treatment apply to an unwell detainee as would be the case for a person in the community.	**HRA**	*supported*	
87.	*Chapter 8*	insert provision for forensic provisions to be subject to	**HRA**	*noted*	

		legislative review.			
88.	*chapter 11*	provision required to ensure suitable access to paperwork for consumers and their legal representatives prior to hearings. This was raised in first exposure draft.	**Legal Aid**	*advice sought from ACAT*	MHCN support the rec, subject to ACAT advice on practicability. MHCC support the rec in principle.
89.	*Chapter 11*	power of presidential members of ACAT to issue warrant for arrest needs to be justified in the ES to allay previously expressed concerns of the ACT Legislative Assembly Scrutiny of Bills Committee.		*noted*	
90.	*section 198*	add definitions of social workers and psychologists.	**Shuhyta**	*supported*	
91.	*section 204*	replace reference to CP with CC	**Edeson**	*supported*	
92.	*Section 258*	Introduce further safeguards against potential misuse of section 258 (2), where guardians have the authority to consent to mental health treatment on behalf of a protected person. This should include guidelines for how it will be determined that a person "expresses willingness to receive the treatment", and who will be responsible for determining this.	**Advocacy for Inclusion**	*not supported but should be in the Code of Practice*	MHCN agree should be in Code CarersACT agree should be in code MHCC agree but would like some discussion.
93.		Consider the need for a guardian to have DMC when appointed and when undertaking the functions (MHCC and others)		*Requires review of guardianship*	Do not want to introduce additional DMC assessment requirements for guardian or PoA
94.	*Section*	The decision-making capacity of a protected person	**MHCN**	*Advice being sought*	MHCC supports the rec.

	258	under a guardianship order should be assessed at the time that a person becomes treated under the Mental Health Act and in accordance with the Mental Health Act, regardless of previous assessments made under guardianship processes.			
95.	*Section 258*	Amend the GMPA (s70A) so that the TT is obliged to notify ACAT of consent provided by a guardian or PoA.	**HRC**	*supported*	
96.	*Section 258*	While s7 of GMPA provides that ACAT must be satisfied that guardianship order is necessary before granting, there is belief that further clarity may be required to ensure unintended consequences from removing mental illness treatment from proscribed medical procedures. Guardianship and PoA Orders should explicitly include mental health treatment for a guardian or PoA to exercise a power to consent to such treatment.	**HRC**	*Agree*	
97.	*Section 258*	Concern that removing mental health treatment from the proscribed medical procedures in the GMPA appears to allow consent to be given by health attorneys under part 2A.	**HRC**	*Will check*	
98.	*def.s*	include a definition of paramedic. What is there is too broad at present. Ambulance Service proposes	**JACS consultation**	*Support*	

		tighter definition that limits it to paramedics with the appropriate training.	**mtng.**		
99.	***conse-quential amend-ments***	section 70 of GMPA Concern that the maximum 6 month consent to treatment under guardianship will in many cases entail undue work when the outcome is known (Suggest 12 months after 12 months)		*For discussion at RAC*	