ACT Government
Health

REF: FOI17/16

[redacted]

Dear [redacted]

Thank you for your application under the *Freedom of Information Act 1989* (the Act), received by ACT Health on 22 March 2017, in which you requested access to Internal Audit reports listed in the ACT Health Annual Report 2015-16.

As Deputy Director-General of Quality Governance and Risk, I am an officer authorised under section 22 of the Act to make a decision in relation to your request.

After conducting a search of the relevant records, ACT Health has identified 330 pages of documentation in its possession that meet the scope of your request. I have decided on a full release of the documentation in accordance with provisions under the Act, as outlined in the Schedule of Documents.

My decision is appealable under the Act. This means that if you are dissatisfied with this outcome you have a right to seek a review under section 59 of the Act. This right of review extends to a review of the adequacy of the search for documents undertaken by ACT Health. If you wish to seek a review you should write to:

The Principal Officer
c/- FOI Coordinator
Ministerial and Government Services
ACT Health
GPO Box 825
CANBERRA ACT 2601

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

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

The Ombudsman
GPO Box 442
CANBERRA ACT 2601

If you have any queries concerning the processing of your request please contact the Freedom of Information Coordinator on (02) 6205 1340 or via email at HealthFOI@act.gov.au .

Yours sincerely

Jane Murkin
Deputy Director-General
Quality, Governance and Risk
ACT Health

4 May 2017

SCHEDULE OF DOCUMENTS

[redacted] - **Audits listed in the annual report – FOI17/16**

FOLIO	ITEM	DATE	STATUS	REASON FOR EXEMPTION	Internet publication – YES/NO – if no, why not
1-56	Internal Audit of Mental Health (Treatment and Care) Act 1994 Involuntary Provisions	January 2015	Full Release		
57-102	Assessment of ACT Health's framework to manage staff misconduct and workplace issues	January 2015	Full Release		
103-138	Internal Audit of Quality Management Processes within the ACT Government Analytical Laboratory (ACTGAL)	October 2015	Full release		
139-160	Assurance Mapping Exercise – Pathology and National Standard No7: Blood and Blood Products	November 2015	Full Release		
161-222	Internal Audit of Clinical Incident Response and Reporting Processes within Canberra Hospital and Health Services	October 2015	Full Release		
223-246	Review of Internal Audit Function	January 2016	Full Release		
247-272	ACT Health Promotion Framework	April 2016	Full Release		
273-310	Records Management (HP Records Manager) Review	November 2015	Full Release		

ACT Government
Health

Internal Audit & Risk Management Branch

Internal Audit of Compliance with *Mental Health (Treatment and Care) Act 1994* Involuntary Provisions

October 2014

Table of Contents

Review Timeframes

Task	Date	Reason for delay (if relevant)
IA&RM Drafted 'Terms of Reference'	10/02/2014	
Entry Meetings	31/03/2014 and 10/04/2014	
IA&RM Revised 'Terms of Reference'	17/04/2014	
Final approval of 'Terms of Reference' (Planning completion)	1/05/2014	
ARMC endorsed 'Terms of Reference'	15/05/2014	
Fieldwork commencement	3/06/2014	
Fieldwork completion	23/10/2014	
Preliminary findings discussions	15/07/2014 29/07/2014 3/09/2014 23/10/2014	
IA&RM drafted discussion paper	3/11/2014	
Draft discussion paper to key stakeholders	28/01/2015	
Exit meetings	22/04/2015 5/05/2015	
IA&RM prepare draft report	23/04/2015	
Draft report circulated for management comments	8/05/2015	
Final draft report received with management comments	24/06/2015	
Final report signed (Report completion)	17/07/2015	
Endorsed by Executive Council	1/07/2015	
Endorsed by Audit and Risk Management Committee	8/09/2015	

1 Executive summary

1.1 Introduction

ACT Health sponsors a number of internal audits as part of the approved Strategic Internal Audit Plan. As part of the approved plan for 2013-14, the Internal Audit & Risk Management Branch performed a review of 'Compliance with *Mental Health (Treatment and Care) Act 1994* Involuntary Provisions'. At the time of this audit an Amendment Bill was passed. Therefore, how the Amendment Act will impact involuntary provisions has also been included in the review.

1.2 Background

In the Australian Capital Territory, in accordance with the *Mental Health (Treatment and Care) Act 1994* Mental Health there are occasions where treatment, care, rehabilitation and protection for are required to be performed involuntarily. These include:

- Emergency Detention –
  - used when Police, Doctors or Mental Health Officers may have reasonable grounds for believing that mentally dysfunctional or mentally ill persons are likely to inflict serious harm to themselves or others; and
  - used if the Magistrates Court has reasonable grounds for believing the accused needs immediate treatment or care because of mental impairment.[1] and
- Psychiatric Treatment Order (PTO).[2] –used where consumers diagnosed with a mental illness and the ACT Civil & Administrative Tribunal (ACAT) has reasonable grounds for believing the person will harm themselves or others;
- Community Care Order (CCO) – used where consumers have a mental dysfunction and the ACAT has reasonable grounds for believing they will harm themselves or others;
- Restriction Orders – used to place a consumer at a specific place or a community care facility;
- Electroconvulsive Therapy Order (ETO)- used to administer electroconvulsive therapy without consent under certain conditions.

The Mental Health (Treatment and Care) Act 1994 and section 309 of the *Crimes Act 1900* set out compliance obligations around these involuntary provisions. This audit reports on the compliance obligations by ACT Health and key controls around them.

1.3 Review objectives

To provide assurance to ACT Health on the effectiveness of key controls ensuring compliance with *Mental Health (Treatment and Care) Act 1994* and *section 309* of the *Crimes Act 1900* regarding imposition of involuntary provisions.

---

[1] Crimes Act 1990 Section 309 1)

[2] ACT Health, MHS-ID *Division, Mental Health, Justice Health and Alcohol & Drug Services* Standard Operating Procedure, January 2012, page 1

1.4 Overall Observations

Compliance with the obligations of the Involuntary Provisions are not just ACT Health responsibilities. The ACT Civil and Administrative Tribunal (ACAT), the Magistrate's Court, the Australian Federal Police, the Public Advocate, the Executive Officer- Care Coordination and Calvary Hospital also have obligations. This audit only covers the ACT Health compliance obligations.

The Amendment Bill for the *Mental Health (Treatment and Care) Act 1994* was passed by the ACT Legislative Assembly on 30 October 2014. The *Mental Health (Treatment and Care) Amendment Act 2014* has a postponed commencement date of 12 November 2015.This audit was performed under the requirements of the *Mental Health (Treatment and Care) Act 1994*. Changes resulting from the Amendment Bill are mentioned as they relate to areas discussed in this report including: addressing areas that were previously silent, for example what occurs if an initial medical assessment is not done within 4 hours; extending 'up to seven day detention' to 'up to 11 days'; renaming 'mental dysfunction' to 'mental disorder'; clarifying wording around the 'forcible giving of medication' to be recorded in Registers. There are new requirements about reporting to the Public Advocate on 'forcible giving of medication' and the Amendment Act has added sections on 'Forensic Mental Health' which relate to people in custody (including *section 309* of the *Crimes Act*). The Amendment Act has a strong emphasis on 'recovery' and a person's 'decision making capacity'. A summary is provided in Appendix C. The additional demands stemming from the Amendment Act will impact ACT Health resources and budgets.

A perceived conflict of interest has arisen due to the return of the administrative role of Executive Officer to the Public Advocate's office. This is due to this officer being both a Public Advocate as well as providing support to the Care Coordinator. To assist with this the Executive Officer for the Care Coordinator role has been defined as an 'administrative role'. What is occurring at the time of this audit is that if the Care Coordinator needs to be represented at the ACAT hearing an ACT Health staff representative will attend. As the Executive Officer role is held by the Public Advocate's Office the individual who holds this position only attends an ACAT hearing as a Public Advocate capacity. This is to help separate the roles of the Public Advocate's Senior Advocate and the Executive Officer being represented by one individual. The ACT Health staff representative is the person who held the role of the Executive Officer for the Care Coordinator before the role was transferred back to the Public Advocate's Office.

The *Mental Health (Treatment and Care) Act 1994* has many requirements to meet certain timeframes. The Tribunal Liaison Officers keep extensive records of faxed documents to show these timeframes are mostly met. Just looking at documents for dates and times does not give credit to the extensive communication required for administering involuntary provisions. Examinations, evaluations, treatment and care was provided to the 659 people who came to an ACT approved health facility in 2013 under involuntary emergency detention. This began the process, which for some, continued to Orders lasting up to six months which then required review. Each person on Orders requires individual 'Treatment Plan and Location Determinations' to be written up each time the person changes locations. The steps between require ACAT hearings, use of delegations and communication with the Public Advocate, Guardians and Attorneys if applicable.

1.5 Summary of key findings

Report section	Findings	Risk Rating	Recommendations
4.1	The Amendment Bill has extended involuntary detention of 'up to seven days' to 'up to eleven days'. It is intended that this additional four days will give more time for the person to have and respond to medication, treatment and care. The Amendment Bill has requirements for the Minister to invite public submissions and review the maximum period of detention of up to eleven days and five aspects of Orders, reporting to the Legislative Assembly.	Low	1. ACT Health should prepare a timeline and establish monitoring processes to support the Minister's requirements to report on up to eleven day detention and five aspects of Orders.
4.1	The current *Mental Health (Treatment and Care) Act 1994* is silent on what happens if the initial examination does not occur within four hours. The Emergency Department does not release an intoxicated person and keep them as a 'duty of care'. The Amendment Bill does define what should occur if a person has not been examined within 4 hours of the admission time to the approved health facility. The Amendment Bill also gives the person in charge of the facility grounds to continue to detain a person. A further two hours is being added to the four hours for an admission to the approved health facility. If this occurs there is an added requirement that the person in charge of the mental health facility immediately contact the Chief Psychiatrist at the four hour point and ensure the examination occurs within the next two hours. The Public Advocate also needs to be informed of the failure to examine the person within four hours and the reasons for the failure.	Low	2. Train ACT Health staff who work with intoxicated people brought to the Emergency Department to assist them understand 'duty of care' under common law principles and when Emergency Detention may apply. 3. ACT Health should clarify delegations for the person in charge of the mental health facility and the Chief Psychiatrist relating to notifications required if an initial examination has not occurred within four hours. Include this information in the relevant Standard Operating Procedure (SOP). 4.Clarify the working relations between the Chief Psychiatrist , psychiatrists in private practice and community sector organisations.

Report section	Findings	Risk Rating	Recommendations
4.1	The Amendment Bill includes new requirements relating to the examination requirements for people under Emergency Detention. Therefore the SOPs[3] will require updating and staff will require training on the new medical examination requirements for people brought to the Canberra Hospital under Emergency Detention.	High	5. ACT Health should update all SOPs used to support compliance with the *Mental Health (Treatment and Care) Act 1994* to reflect the new Amendment Act. Also see Recommendation 11
4.1	There is lack of clarity in regards to the commencement of detention. There needs to be additional clarity around whether the admission time is to the Emergency Department or another section of the hospital, for example the Mental Health Assessment Unit. The time of admission to the approved health facility and the detention time are actually the same. What changes is that the person has met the criteria to be detained and this has been authorised by a doctor. This lack of clarity is not assisted by the information requested on the two forms that begin the Emergency Detention Process.	Medium	6. ACT Health should update the forms used to support compliance with the *Mental Health (Treatment and Care) Act* to reflect the new Amendment Bill. Ensure the 'Statement of Action' includes a space for the date and time of admission to a health facility and all forms encompass the current titles and clear and consistent naming conventions.
4.2	Audit was informed that since 1994 when the *Mental Health (Treatment and Care) Act* was introduced the Magistrates Court has requested a report be provided to it only when the person is released. Neither ACT Health or the Magistrates Court produced any written evidence of this change in requirements. The	Medium	7. ACT Health should clarify the reports to go to the Magistrates Court. Document the agreement with the Magistrates Court and adhere to the agreed process for reporting.

[3] Psychiatric and Medical Examination of Involuntary Consumers under the *Mental Health (Treatment and Care) Act 1994*

Report section	Findings	Risk Rating	Recommendations
	practice for ACT Heath to prepare a report on release of a person admitted under section 309 is what occurs at the time of this audit. Therefore, the requirements of the *Mental Health (Treatment and Care) Act 1994* to notify the Magistrates Court of the results of an examination or the reason for involuntary detention and care are not occurring. Apparently this is at the request of the Magistrates Court.		
4.2	There are two requirements at the time of release of a person admitted under *section 309* of the *Crimes Act 1900* – • A report for the Magistrates Court; and • for the person to be released into the custody of a police officer. To prepare the report for the Magistrates Court, at the time of discharge, the doctor completes a proforma which is loaded on to Mhagic. The report goes to the Magistrates Court. The specific information to be entered into Mhagic is not included in the SOP's step by step instructions of releasing a person after an admission to the Adult Mental Health Unit. Mhagic is what is currently being used by the 'Forensic Court Liaison Officers' to find out if a person has been admitted under *section 309* have been released. Therefore, it is important that Mhagic is being completed by all areas of ACT Health to assist communication. Therefore, the SOP should be expanded to include specific information to be entered into Mhagic for releasing a person after admission of the Adult Mental Health Unit.	Medium	8. Forensic Mental Health Services in conjunction with Mental Health Assessment Unit and the Adult Mental Health Unit should complete the draft SOP 'Adult Consumers on Custodial Orders (s 309 of the Crimes Act 1900)' prior to having it approved, communicated and implemented.

Report section	Findings	Risk Rating	Recommendations
4.2	As a result of a new 'Tribunal Liaison Officer' role being created is that the 'Court Liaison Officers' are no longer informed about the processes taken for people admitted under *section 309*. Therefore the SOP has been reviewed to improve the communication process between the Mental Health Court Liaison Officer, Consultant Psychiatrist, The Canberra Hospital Emergency Department/ Triage staff, Mental Health Assessment Unit staff and the Adult Mental Health Unit.	Medium	9. Same as Recommendation 8.
4.3	The Chief Psychiatrist is not compliant, in all cases, with the *Mental Health (Treatment and Care) Act 1994* requirement to prepare a written 'Treatment Plan and Location Determination' within five working days of the Psychiatric Treatment Order being made and to provide a copy to the ACAT as soon as practicable.	Medium	10. i) ACT Health should incorporate the 'Treatment Plan and Location Determination' to be submitted for all assessments for a 'Psychiatric Treatment Order' or a 'Community Care Order'. Incorporate wording to show that if an order is made the 'Treatment Plan Location Determination' will be regarded as the determination written within 5 working days of Order being made; ii) Incorporate the changes in 9 i) into Mhagic; iii) Update the 'Care of Consumers subject to Psychiatric Treatment Orders (PTOs)' accordingly; and iv) Distribute the 'Treatment Plan and Location Determination' to: the ACAT; the Public Advocate; and a guardian or an attorney if applicable.
4.3	There is a great deal of the corporate knowledge of the *Mental Health (Treatment and Care) Act 1994* sitting with the Tribunal Liaison Officers and other key ACT Health	10.Low	11. i) The Chief Psychiatrist should ensure there are succession planning and knowledge management strategies for key ACT Health staff who hold the corporate knowledge of

Report section	Findings	Risk Rating	Recommendations
	staff which may be lost if these staff leave ACT Health. There is also the issue of what processes are followed if a person on an ED3 is moved from Emergency Department to another ward for medical treatment. In these incidences if Ward staff are not aware of the Involuntary Provision processes, or if the Tribunal Liaison Officer has not been informed the *Mental Health (Treatment and Care) Act 1994* the timeframes may not be met.	11.High	the *Mental Health (Treatment and Care) Act 1994*. ii) The Executive Director Policy and Government Relations should ensure succession planning and knowledge management strategies for ACT Health staff who hold the corporate knowledge of the *Mental Health (Treatment and Care) Act 1994*. 12. ACT Health should ensure the ACT Health staff who will treat people on involuntary provisions are trained in areas of compliance for the *Mental Health (Treatment and Care) Amendment Act 2014*.
4.4	There is supposed to be a Register of Involuntary restraint, seclusion or administration of medication to record additional levels of restraint, seclusion or administration of medication than would usually occur under the Community Care or Restriction Order. The Care Coordinator delegates the coordination of care providers, to an individual, under a Community Care Order. The locations of people on Community Care Orders spreads across ACT. Audit were told that staff in aged care facilities would not be trained in, or want to, 'restrain, seclude or forcefully give medication'. Therefore it would be anticipated that the person would be taken to a health facility. In the Amendment Bill both registers now require the three components; restraint, seclusion and administration of medication. The wording in the Amendment Bill has been improved to show that it is 'forcibly given medication' that is expected to go into the Register, not just routine administration of medication.	Medium	13. ACT Health should consider combining the registers required for the Chief Psychiatrist and the Care Coordinator to record restraint, seclusion and forceful administration of medication. Ensure the Register(s) has a column to indicate whether the restraint, seclusion or forceful administration of medication has been under the delegation of the Chief Psychiatrist or the Care Coordinator and another column to indicate which type of order the person is on.

Report section	Findings	Risk Rating	Recommendations
4.4	As per Recommendation 5 all SOPs should be updated to reflect the *Mental Health (Treatment and Care) Amendment Act 2014*, including SOPs relating to the Care Coordinator. However, there is the added complication with the Executive Officer role with the Public Advocate's Office that policy and procedures are written and approved within the Justice Community Safety Directorate (JACS). This recommendation is made on the condition that the Executive Officer for Care Coordinator role still exists. In May 2015 audit was informed that ACT Health and JACS were in discussion about the Care Coordinator role.	Low	14. ACT Health and Justice Community Safety Directorate should review the future processes of the Care Coordinator role. If applicable, ACT Health and the Executive Officer for the Care Coordinator should develop a process to have policies and procedures for the Care Coordinator Executive Officer role be approved and adopted for both JACS and ACT Health.
4.6	The requirement for the person in charge of the psychiatric institution to keep records of Electroconvulsive Therapy Treatments for 5 years is being met[4]. However, there were incidences where the lines in the ECT Register were left blank. Therefore the record is not complete. The register itself is a self bound document with pages falling out. Sticky tape has been used to keep pages with the document. The Electroconvulsive Therapy Register does not have the professional appearance of a legal document.	Medium	15. ACT Health should upgrade the Electroconvulsive Therapy Register to a bound book with numbered pages. Ensure all Electroconvulsive Therapy Treatments are recorded consistently in the Register.

[4] Act Reference Part 7 Subsection 7.2.6 section 58

2 Management sign off

This report has been reviewed and discussed with management of ACT Health. Management has had the opportunity to express any comments on the findings and recommendations outlined in this report.

17/7/15

Ian Thompson — Date
Deputy Director-General, Canberra Hospital and Health Services
ACT Health

1-7-15

Kim Smith — Date
A/g Deputy Director-General, Strategy and Corporate
ACT Health

2/7/15

Katrina Bracher — Date
Executive Director, Mental Health, Justice, Health and Alcohol and Drug Services
ACT Health

3/7/15

Dr Denise Riordan — Date
A/g Director of Clinical Services, Chief Psychiatrist
ACT Health

10/7/2015.

Linda Kohlhagen — Date
Executive Director, Rehabilitation, Aged and Community Care, Care Coordinator
ACT Health

29/6/15

Rosemary O'Donnell — Date
A/g Executive Director, Policy and Government Relations
ACT Health

26/6/15

Sarwan Kumar — Date
Internal Audit & Risk Manager
ACT Health

3 Background

The Orders for Involuntary Provisions under *the Mental Health (Treatment and Care) Act 1994* broadly break into two categories:

1) Orders under the role of the Chief Psychiatrist:
   Emergency Detention, Psychiatric Treatment Orders and Electroconvulsive Therapy Orders; and
2) Orders under the role of the Care Coordinator:
   Community Care Orders and Restrictions Orders.[5]

The Chief Psychiatrist and the Care Coordinator are supported by different staff members. So although the application for Orders all go to the ACT Civil and Administrative Tribunal (ACAT), the applications follow different paths. During the time of this audit the support for the Care Coordinator - the Executive Officer for the Care Coordinator moved outside ACT Health to the Public Advocate's Office.

In the ACT, the Minister for Health approves Mental Health Facilities where a person under Emergency Detention[6] or a Psychiatric Treatment Order[7] may be taken for treatment and care. There are a number of approved Mental Health Facilities in the ACT:

- The Adult Mental Health Unit located at the Canberra Hospital;
- Brian Hennessey Rehabilitation Centre located at Hennessey House;
- Older Persons Mental Health Inpatient Unit (OPMHIU) located at Calvary Hospital;
- Intensive Care and Coronary Care Units, Theatre Complex, Ward 5E and the Aged Care Rehabilitation Unit at Calvary Hospital; and
- The Canberra Hospital can accommodate mentally ill patients throughout the whole hospital.

ACT Health is compliant with Section 48 (1) (a) of the Act as all these locations have the relevant Notifiable Instrument or Disallowable Instrument as required by *the Mental Health (Treatment and Care) Act 1994*. [8]

The ACT Civil and Administrative Tribunal (ACAT) sits outside ACT Health and is part of the Justice and Community Safety Directorate. ACAT functions include: granting, varying, reviewing or revoking Orders.

The Public Advocate's Office is provided with the ACAT hearing applications for people with a mental illness or mental dysfunction. The Act requires the Public Advocate is notified about many components of the Involuntary Provisions Orders by both ACT Health and the ACAT.

There are multiple parties involved in the application of the Involuntary Provisions in the ACT. This audit has only looked at ACT Health compliance relating to these provisions.

---

[5] Although under the Act Restriction Orders can be made for both Psychiatric Treatment Orders and Community Care Orders, in practice Restriction Orders are used for Community Care Orders. All the 2013 Restriction Orders were connected to Community Care Orders.

[6] Act reference Part 5 section 37

[7] Act reference Part 4 Division 4.4 section 29 (1)

[8] Act reference Part 5 section 48 part 1) (a)

4 Detailed Findings

The following section details the key findings of the review, including associated recommendations and management response.

Risk assessment of findings

Findings identified in the review process were allocated risk ratings in accordance with risk rating definitions in the Health Directorate Integrated Risk Management Guidelines. Further details are provided at Appendix D. The following table provides the level of management action required for each risk rating category:

Rating scale for individual findings	
Extreme Risk	All possible action is taken at Executive level, to avoid and insure against these risks.
High Risk	Generally managers are accountable and responsible personally for ensuring that these risks are managed effectively.
Medium Risk	Accountability and responsibility for effective management of these risks is delegated to line managers at an appropriate level.
Low Risk	These risks are managed in the course of routine procedures, with regular review and reporting through management processes.

4.1 Emergency Detention

Background for Emergency Detention

Emergency Detention comprises of 3 stages:

1) Bringing a person to an approved Health Facility who is believed to have a mental illness or mental dysfunction. This can be done by police, doctors or mental health officers or under *section 309* of the *Crimes Act*. The Amendment Act also authorises paramedics to apprehend a person.[9]

For a person brought to the Canberra Hospital under *section 37* or *section 309* of the Acts there is a requirement that the person has a medical examination within 4 hours from the admission time. Within 24 hours of admission time a psychiatrist is also required to perform an assessment.[10]

2) The Doctor who performs the initial medical examination, if he/she believes the person to have a mental illness or mental dysfunction, fills out a form to request a further up to three day detention.[11] This detention is authorised by the doctor.

3) Before the end of the up to three day detention there is an option to extend the detention for up to an additional of up to seven days. For this to occur the case is put before the ACAT to approve the extension on the detention. This final Emergency Detention stage is the 'Emergency Detention Orders'.[12]

This audit tested the: 'Statement of Action Taken' to apprehend a person to undertake a mental health assessment; authorisation of Involuntary Detention by a doctor; applications for an additional period not exceeding 7 days made by a psychiatrist; notifications by a doctor about detention; and communication offered for a person during detention.

Findings

The key controls for Emergency Detention are:

- Completion of the 'Statement of Action' (Apprehension by a doctor or mental health officer) – 'Green Form' by the police officer, doctor or mental health officer bringing the person to the approved health facility (for the person in charge of the facility)[13];
- The person in charge of the facility placing the 'Statement of Action' on the clinical records of the person whom it concerns[14];

---

[9] Mental Health (Treatment and Care) Amendment Bill 2014, section 11 (3)

[10] This is a statutory authorisation

[11] This is a statutory authorisation

[12] 'Emergency Detention Order' under Part 5 section 41 (2)

[13] Act reference Part 5 Section 39 (1)

[14] Act reference Part 5 Section 39 (2)

- Completion of the 'Authorised /Notification Involuntary Detention' – 'Blue Form' by the examining doctor, within the first 4 hours of detention, to detain a person in hospital for up to three days;[15]
- the Application to ACAT for a Emergency Detention Orders completed by the examining psychiatrist using the form 'Application for further period of detention (not exceeding 7 days)' to detain a person in hospital for up to a further seven days. [16]

The last two steps are usually performed by the Mental Health Assessment Unit once a person has been admitted to the Emergency Department of the Canberra Hospital.

An external key control for the Emergency Detention Order is the ACT Civil and Administrative Tribunal hearings to make, vary, review and revoke Orders.

To put the Involuntary Provision Orders tested into context, below is a table showing how many Orders, or related items, there were in 2013.

Description	2013 totals
Total Emergency Detention for up to 3 days (ED3s)	659
Total Emergency Detention for up to 3 days (ED3) that did not go to an Emergency Detention for 7 days of less (ED7)	333
Total Emergency Detentions for 7 days or less (ED7s)	326
Total Psychiatric Treatment Orders from ED7s *	186
Total Community Care Orders**	12
Total new Restriction Orders	4

* This number of Psychiatric Treatment Orders does not include Psychiatric Treatment Orders granted other ways or reviews of Psychiatric Treatment Orders.
** This represents the number of Community Care Orders, not the number of people on Community Care Orders.

Timing for up to 3 day and up to 7 day detention

When a doctor examines a person within the first four hours of being admitted to the Canberra Hospital the doctor may authorise a three day detention. This is known as an 'ED3'. In order to detain a person for three days the examining doctor must believe: the person has a mentally dysfunction or is mentally ill; and as a consequence requires immediate treatment or care; or that the person's condition will deteriorate within three days such that the person would require treatment or care; the person has refused to receive treatment or care; and detention is

[15] Act reference Part 5 Section 41 (1)

[16] Act reference Part 5 Section 41 (2)

necessary of the person's own safety, social or financial wellbeing or for protection of members of the public; and adequate treatment or care cannot be provided in a less restrictive environment.[17]

If this is the case, the doctor completes an 'Authorised /Notification Involuntary Detention' – 'Blue Form' to detain a person for three days. If it is decided within these three days that a person requires further detention then an application is made to the ACAT for a further period of detention, not exceeding 7 days. This is known as an 'ED7'. The examining psychiatrist makes an application for an ED7 before the period of detention (ED3) expires. [18]

The Act does not specify any grounds the psychiatrist uses to make the assessment for an additional up to 7 day detention application. To cover the application for an ED7 the Act states – 'Where a) a person is detained under subsection (1) [An ED3] and (b) an application for further detention is made by a psychiatrist before the detention expires; the ACAT may order that, on the expiration of that period the person be so detained for the further period (not exceeding 7 days) specified in the order. The Amendment Bill now specifies what criteria the chief psychiatrist would use to put in an application for detention orders, that are now up to eleven days.[19] The ACAT are required to review the decision of the doctor within 2 days of receiving the application. The ACAT make the ruling on the application.

Doctors or psychiatrists make a judgement on whether an 'ED3' is going to require an 'ED7'. Therefore, if a person who may have to be detained using an ED3 and an ED7 is admitted to the Canberra Hospital on Thursday evening or Friday the paperwork for the application to ACAT for an 'ED7' has to be prepared on the day the person was admitted to hospital. Audit was informed that the three day detention is a timeframe established alongside the *Humans Rights Act 2004*. The three day detention has been established with the intention of not having a person detained for an undue length of time. The up to three day length of detention was discussed during the development of the Amendment Bill and remained unchanged.

Given the weekends, a person requiring detention for more than 3 days, admitted each Thursday night and Friday, accelerates the Emergency Detention process. This results in doctors, psychiatrists, the Mental Health Assessment Unit, the Tribunal Liaison Officers and the ACAT all being in communication about possible ACAT hearings and completing the required paperwork. The person involved is faced with a doctor or psychiatrist explaining to them that they are possibly going to be held in detention for three days and a further detention of up to seven days.

To assist in meeting the Emergency Detention timeframes on public holidays the ACAT has a roster of Presidential Members who can be contacted to make rulings on applications under section 77 of the Act. An 'ED7' can be constituted by a Presidential Member. ACT Health is informed of which Presidential Member will be available a week prior to the holiday. There are certain applications that require an ACAT Hearing.[20]

---

17 Act reference Part 5 Section 37 (2)

18 Act reference Part 5 Section 41 (2)

19 Amendment Bill 2014 Section 41 Authorisation of Involuntary Detention (2)

20 Act reference Part 9 Section 78

Implication

Timing established in the *Mental Health (Treatment and Care) Act 1994* for emergency detention can result in a person being notified of a possible detention of up to 10 days (3 day and 7 day detention) on the day the person is admitted to the Canberra Hospital. This results in doctors, psychiatrists, the Mental Health Assessment Unit, the Tribunal Liaison Officers and the ACAT all being in communication about possible ACAT hearings and completing the required paperwork.

Audit was informed that as the ACAT are having hearings so close to the point in time when they are very unwell this often results in the person being put on orders for up to six months. (See section 4.3 Psychiatric Treatment Orders and section 4.4 Community Care Orders). Audit was also informed that it is important for the person to have a chance to be heard. The ACAT hearings provide this opportunity.

An extract from the Amendment Bill states *'The Act's criteria for the up-to-three day's doctors authorisation and the ACAT order are such that the person is likely to have been quite unwell to have either imposed on them.'*[21] For this reason the Amendment Bill has extended the up to seven days to up to eleven days. It is intended that this additional four days will give more time for the person to have and respond to medication, treatment and care.

The Amendment Bill has a requirement for the Minister to invite public submissions and review the maximum period of detention of up to eleven days[22]. This is required to occur 18 months after the November 2015 commencement. The Minister must present a report to the Legislative Assembly not later than one year after the day the review commences. The report is to evaluate the intended benefit on the course of treatment to improve the person's experience of care provided by increasing the detention of up to seven days to a detention of up to eleven days.

The Amendment Bill also requires the Minister to report on: Psychiatric Treatment Orders, Community Care Orders, Forensic psychiatric Treatment Orders, Content of Forensic Psychiatric Treatment Order and Forensic Community Care Orders[23]. These reports are to go to the Legislative Assembly within four years of the November 2015 commencement date of the Amendment Act 2014. The Minister is required to invite public submissions and review the operation of these Orders three years after the November 2015 commencement[24].

Recommendation 1

ACT Health should prepare a timeline and establish monitoring processes to support the Minister's requirements to report on up to eleven day detention and five aspects of Orders.

Risk Rating

Low

---

[21] Page 25 o f the Explanatory Statement for Mental Health (Treatment and Care) Act 1994 Amendment Bill 2014

[22] Mental Health (Treatment and Care) Amendment Bill 2014, section 145A (4) (a)

[23] Mental Health (Treatment and Care) Amendment Bill 2014, section 145A (2)

[24] Mental Health (Treatment and Care) Amendment Bill 2014, section 145A (1) (a), (b), (c), (d) and (e)

Responsible Officer
Chief Psychiatrist

Management comments
Agreed. Records will continue to be maintained to assist reporting on the number of Orders resulting from 11 day detentions, for comparison with existing records.

Implementation timeframe
September 2015

Intoxicated people being admitted to the Emergency Department

The issue of intoxicated people being admitted to the Emergency Department by the police was raised during this audit. Intoxicated means either through use of drugs and/ or alcohol and/ or other substances. [25] The *Mental Health (Treatment and Care) Act 1994* allows police officers to apprehend a person and take him or her to an approved health facility. This is done if a police officer has reasonable grounds for believing that the person is mentally dysfunctional or mentally ill and has attempted or is likely to attempt to commit suicide or to inflict harm to himself or herself or another person.[26] To meet the criteria of the *Mental Health (Treatment and Care) Act 1994* a person is not regarded as mentally dysfunctional or mentally ill if they have only taken alcohol or any other drug.[27]

Under the *Intoxicated People (Care and Protection) Act 1994* a person working with an intoxicated person, on licensed premises, is able to arrange for an intoxicated person to be transferred to the Emergency Department of the Hospital if a carer at a licensed place is satisfied that an intoxicated person requires, or may require, medical treatment[28] The *Intoxicated People (Care and Protection) Act 1994* states that if an intoxicated person, in a public place, due to being intoxicated may cause injury to himself, herself or other or incapable of protecting himself or herself from physical harm the police may take the person into custody and detain the person.[29] The police station is the location of the detained person for the *Intoxicated People (Care and Protection) Act 1994* for up to 12 hours. The Act is silent on police bringing intoxicated people to the Emergency Department of the Hospital, unless the police have been asked by a carer when arranging the intoxicated person to be transferred to the emergency department of the Hospital.[30]

Audit was informed that there an increasing number of intoxicated people being brought to the Emergency Department by the police.

When an intoxicated person is brought into the Emergency Department the person may be held under a duty of care or detained using an 'ED3'. As mentioned above a person is not regarded as

---

25 Intoxicated People (Care and Protection Act 1994,Dictionary

26 Act reference page 37, Part 5 Section 37 (1) (a) and (b)

27 Act reference Part 1 Section 5 (j)

28 Intoxicate People (Care and Protection) Act 1994 Part 2 section 10

29 Intoxicate People (Care and Protection) Act 1994 Part 2 section 4 (1)

30 Intoxicated People (Care and Protection) Act 1994 Part 2 Section 10

mentally dysfunctional or mentally ill if they have only taken alcohol or any other drug.[31] Therefore the psychiatrist has to make an assessment on whether the intoxication is related to an underlying issue, like depression. The *Mental Health (Treatment and Care) Act 1994* requires the initial assessment of a person on an 'ED3' to be within four hours of admission.

Audit was informed when a person is intoxicated a process is followed to establish intoxication levels within the first four hours. (This process is not part of the Emergency Detention process). It is then usual practice to let an intoxicated person wear off the effects of intoxication. If a person has been detained on an ED3, after the person has woken the psychiatrist has to assess if the intoxication is based on an underlying issue. The table on page 16 shows that the ED3 initial assessment results in 50 percent of people brought to an approved health facility being release with no further detention (333/659 = 50 %). These figures are the overall number of ED3s in 2013 and the number that did not go onto an ED7. It is not possible to determine how many of these were brought to the approved health facility intoxicated.

Implication

The *Mental Health (Care and Treatment) Act 1994* is not written with the intention of assessing intoxicated people. The audit testing did have an example of a person not being examined within 4 hours due to being intoxicated. The current *Mental Health (Treatment and Care) Act 1994* is silent on what happens if the initial examination does not occur within four hours. The Emergency Department does not release an intoxicated person and keep them as a 'duty of care'. Doctors apply 'duty of care' to 'save a person's life'.

Recommendation 2

Train ACT Health staff who work with intoxicated people brought to the Emergency Department to assist them understand 'duty of care' under common law principles and when Emergency Detention may apply.

Risk Rating

Low

Responsible Officer
Chief Psychiatrist

Management comments
Agreed. A staff member has been assigned to developing the training across ACT Health to be ready in November 2015 when the new Act commences.

Implementation timeframe
November 2015

---

[31] Act reference Part 1 Section 5 (j)

Implication continued

The Amendment Bill does define what should occur if a person has not been examined within 4 hours of the admission time to the approved health facility. The Amendment Bill also gives the person in charge of the facility grounds to continue to detain a person. The Amendment Bill requires the following:

> *However, the person in charge of the facility may continue to detain the subject person if he or she believes on reasonable grounds that,*
> *if the subject person is released without examination—*
> *(a) the subject person's health or safety is, or is likely to be, substantially at risk; or*
> *(b) the subject person is doing, or is likely to do, serious harm to others; or*
> *(c) the subject person is seriously endangering, or is likely to seriously endanger, public safety.*
> *If the subject person continues to be detained under subsection (3)—*
> *(a) the person in charge of the approved mental health facility must immediately tell the chief psychiatrist that the subject person has been at the facility for 4 hours without an initial examination; and*
> *(b) the chief psychiatrist must examine the person as soon as possible and within 2 hours of being told about the detention.*
> *(5) If the subject person is not examined within the time required under subsection (4), the person in charge of the approved mental health facility must release the subject person in accordance with the method the person was brought into Emergency Detention.*
> *(6) The person in charge of the approved mental health facility must tell*
> *the public advocate, in writing, about any failure to examine a person within the time required under subsection (2) or (4) and the reasons for the failure.*

In summary, if required, a further two hours is being added to the four hours for an admission to the approved health facility. If this occurs there is an added requirement that the person in charge of the health facility immediately contact the Chief Psychiatrist at the four hour point and ensure the examination occurs within the next two hours. The Public Advocate also needs to be informed in writing of the failure to examine the person within four hours and the reasons for the failure.

Given these new requirements for the person in charge of the mental health facility and the Chief Psychiatrist consideration needs to be given to delegations for both these positions.

Recommendation 3

ACT Health should clarify delegations for the person in charge of the mental health facility and the Chief Psychiatrist relating to notifications required if an initial examination has not occurred within four hours. Include this information in the relevant Standard Operating Procedure (SOP).

Risk Rating
Low

Responsible Officer
Executive Director Policy and Government Relations Management comments

Management Comments
Agreed. Policy and Government Relations will work closely with the Chief Psychiatrist and the Deputy Director General of the Canberra Hospital & Health Services to develop a Standard Operating Procedure clarify delegations for the person in charge of the mental health facility and the Chief Psychiatrist relating to notifications required if an initial examination has not occurred

within four hours. The SOP will be finalised prior to prior to the new ACT Mental Health Act becoming operational 12 November 2015.

Implementation timeframe
September 2015

Private practice psychiatrists and community sector organisations

Under the Amendment Bill if the initial four hour examination did not occur the Chief Psychiatrist, or delegate, is to perform an initial examination within two hours of being notified. This examination may result in authorised detention at an approved mental health facility for a period not exceeding 3 days. The person in charge of the health facility is responsible for the detention of a person under Emergency Detention.

There are people who have treatments voluntarily, attending private psychiatrists and community sector organisations. On occasion these people may require treatment and care involuntarily. This is when the *Mental Health (Treatment and Care) Act 1994* will be enacted. It remains unclear in the Amendment Bill what authority the Chief Psychiatrist's statutory position has relating to psychiatrists in private practice and community sector organisations. Audit was informed that the Chief Psychiatrist has the responsibility to select whether to take on an individual under involuntary provisions. The Chief Psychiatrist has authority over the individual, not the psychiatrists in private practice. If the community sector organisation is under a contract with the ACT Government then the Chief Psychiatrist has the authority outlined in the contract. Where there is no contract between the community sector organisation and the ACT Government the Chief Psychiatrist has no authority.

Recommendation 4

Clarify the working relations between the Chief Psychiatrist, psychiatrists in private practice and community sector organisations.

Risk Rating
Low

Responsible Officer
Executive Director Policy and Government Relations Management comments

Management Comments
Agreed. Policy and Government Relations will work closely with the Chief Psychiatrist to clarify the working relations between the Chief Psychiatrist, psychiatrists in private practice and community sector organisations under the new Mental Health Act prior to the new Act becoming operational 12 November 2015.

Implementation timeframe
September 2015

Examination requirements

The Amendment Bill specifies the initial examination (within four hours) by a doctor must be 'in person' and the subsequent physical examination (within twenty four hours) by a doctor **and** a psychiatrist must be 'thorough'[32]. The current SOP 'Psychiatric and Medical Examination of Involuntary Consumers under the *Mental Health (Treatment and Care) Act 1994*'[33], reflects section 43 of the 1994 Act. Section 43 was revised in 1999, to provide '*that both a physical and psychiatric examination is completed within 24 hours for every person detained under emergency detention provisions, without providing that a psychiatrist must perform both examinations. In practice, a medical officer or registrar performs the physical examination leaving the specialist psychiatric consultant to attend to his or her core responsibilities for the psychiatric examination. This process is considered best practice as well as being the best use of available resources*'.

Implication

The Amendment Bill includes new requirements relating to the examination requirements for people under Emergency Detention. Therefore the SOP[34] will require updating and staff will require training on the new medical examination requirements for people brought to the Canberra Hospital under Emergency Detention.

Recommendation 5

Update all SOPs used to support compliance with the *Mental Health (Treatment and Care) Act 1994* to reflect the new Amendment Act.

Risk Rating

Medium

Responsible Officer
Chief Psychiatrist

Management comments
Agreed. Mental Health, Justice Health and Alcohol and Drug Services are working with the HealthCARE Improvement Division with the intention of having SOPs updated and approved prior to November 2015 when the new Act commences.

Implementation timeframe
September 2015

---

[32] Amendment Bill 2014 reference page 82 41AA Medical examination of a detained person (1) (a) and (b)

[33] Page 3, CHHS13/590, Psychiatric and Medical Examination of Involuntary Consumers under the *Mental Health (Treatment and Care) Act 1994*

[34] Psychiatric and Medical Examination of Involuntary Consumers under the *Mental Health (Treatment and Care) Act 1994*

Documentation improvements

The gap analysis of policy and procedures showed that in the SOP titled 'Psychiatric and Medical Examination of Involuntary Consumers under the *Mental Health (Treatment and Care) Act 1994'* there is lack of clarity in regards to the commencement of detention. The SOP address the detention from the time the doctor authorises the detention. [35] Detention according to the Act starts from the time[36] the patient was admitted to the hospital and within the next 4 hours the patient must be assessed. There needs to be additional clarity around whether the admission time is to the Emergency Department or another section of the hospital, for example the Mental Health Assessment Unit.

The 'time of admission to the approved health facility' and the 'detention time' are the same. What changes is that the person has met the criteria to be detained and this has been authorised by a doctor.

This lack of clarity is not assisted by the information requested on the two forms that begin the Emergency Detention Process:

1) The 'Statement of Action Taken', known as the green form; and

2) The 'Authorisation /Notification Involuntary Detention', known as the blue form for an ED3.

The 'Statement of Action Taken' form requires one time and date, referred to as 'time and date of action'. As this form is completed by a police officer, a doctor or a Mental Health Officer it is not clear that this 'action' is the time the person was brought to the approve health facility. The person may have been apprehended by the police hours before.

The 'Authorisation/ Notification Involuntary Detention' requires three dates and times. These are as follows: 'Time and date of admission', 'Time and date of examination' and 'Involuntary detention commenced in... at the Canberra Hospital at time and date'. From the samples tested the 'time of admission' at the top of the form where the same as the 'Involuntary Detention commenced' time at the end of the form. The form is like this because if a person is not detained the time is not filled out at the end of the form. This time a person is detained is also recorded if an application for a further period of detention not exceeding 7 days is required. Due to the Act requirements these times are reviewed by the Public Advocate and the ACAT. Ensure the green form and the blue form have the 'Tribunal Liaison Officer' fax number to assist ACT Health staff meet the requirements of the Act.

The forms are now also out of date as they include old titles like:
'the Mental Health Tribunal' instead of 'the ACT Civil & Administrative Tribunal';

'the Office of the Community Advocate' instead of 'the Office of the Public Advocate' and

'Court Liaison Officer' instead of 'Tribunal Liaison Officer'.

---

35 CHHS13/590 page 1 para 1 Psychiatric and Medical Examination of Involuntary Consumers under the *Mental Health (Treatment and Care) Act 1994*

36 Act reference Part 5 Section 40 (1).

Implication

'Time of action' can be and is interpreted in different ways by different people. Therefore the 'Statement of Action Taken' form should replace this with 'time of arrival at hospital'. Discussion with key staff indicated this form should also include 'time of apprehension' and 'time of release'. The time and date of admission is required on the 'Authorisation / Notification Involuntary Detention' (blue form). The blue form requires the time and date of examination. The forms having outdated names for entities requiring copies will not assist ACT Health staff to meet compliance obligations.

Recommendation 6

ACT Health should update the forms used to support compliance with the *Mental Health (Treatment and Care) Act 1994* to reflect the new Amendment Bill. Ensure the 'Statement of Action Taken' includes a space for the date and time of admission to a health facility and all forms encompass the current titles and clear and consistent naming conventions.

Risk Rating

Medium

Responsible Officer
Chief Psychiatrist

Management comments
Agreed. Updated forms will assist meet compliance with the Mental Health (Treatment and Care) Amendment Act 2014.

Implementation timeframe
September 2015

4.2 *Section 309* of the *Crimes Act 1900*

Background for *section 309* of the *Crimes Act 1900*

If the Magistrates Court has reasonable grounds for believing that an accused person needs immediate treatment or care because of mental impairment the court may apply *section 309* of the *Crimes Act 1900*. If *section 309* is applied the court is not required to submit an application to the ACAT. Instead the accused is taken by a police officer or corrections officer to an approved health facility for clinical examination for the purpose of deciding whether the accused needs immediate treatment or care because of mental impairment.

Once a person under *section 309* of the *Crimes Act 1900,* has been brought to an approved health facility, usually the Emergency Department of the Canberra Hospital, the Emergency Detention process from the *Mental Health (Treatment and Care Act) 1994* is applied.

The *Mental Health (Treatment and Care) Act 1994* (the Act) requires that if a person is brought to an approved health facility under *section 309* the following documentation is required:

- a copy of the Court Order (to be provided to the person in charge of the facility) ;[37]
- the 'Statement of Action', the Emergency Detention 'Green Form' completed by the police officer, bringing the person to the approved health facility (for the person in charge of the facility - to be included in the person's clinical records) [38]

Once a person admitted to the approved health facility under *section 309,* has been examined by a doctor, the Magistrate Court must be notified of the results of the examination. [39] If the doctor authorises the involuntary detention of the person the court must be notified of reasons for the involuntary detention and care.[40] If a person admitted under *section 309* is discharged the person must be released into the custody of a police officer.[41]

The Amendment Bill has been expanded relating to *section 309* of the *Crimes Act* and is covered under 'Forensic Mental Health Orders'. This section is broader than just *section 309* of the *Crimes Act*, but is similar. For 'Forensic Mental Health Orders' the measure will not be decision making capacity, but rather refusing to accept treatment. There is also a new measure to formally recognise people accused of a federal offence found unfit to plead and/or acquitted because of a mental illness.

The audit tested: Notification to the Magistrates Court of the results of the doctor's examination and the reason for involuntary detention and care; receipt of and storing Court Orders; examination by a doctor within four hours of admission; a second physical and psychiatric examination within 24 hours of being detained; Authorisation by a doctor of involuntary detention; notification of certain persons about detention; orders to release and duty to release.

---

[37] Act reference Part 5 section 38A

[38] Act reference Part 5 section 39 (1) & (2)

[39] Act reference Part 5 section 41 A (a)

[40] Act reference Part 5 section 42 (3)

[41] Act reference Part 5 section 41 A (b) (ii)

Findings

The key controls for *section 309* of the *Crimes Act 1900* were:

- keeping a copy of the Court Order by the person in charge of the facility;
- including a copy of the 'Statement of Action' / 'Green Form' in a person's clinical records;
- Notifying the Magistrates Court of the results of an examination conducted by a doctor under an order under *section 309* of *the Crimes Act 1900*;
- Notifying the Magistrates Court of the reason for involuntary detention and care;
- Releasing the person admitted under *section 309* into the custody of a police officer.

Court Orders

The requirement to provide a copy of the Court Order is the responsibility of the Magistrates Court. Therefore it is not in the scope of this audit. During the audit it was observed that a copy of the Court Order is provided at the time of presentation and ACT Health staff securely destroyed the Court Order upon discharge of the patient. This is done as the Court Order is not considered to be a medical record. [42]

Communication to the Magistrates Court on results of examination and reason for detention

Audit was informed that since 1994, when the *Mental Health (Treatment and Care) Act 1994* was introduced, the Magistrates Court has requested a report be provided to it only when the person is released. Neither ACT Health or the Magistrates Court produced any written evidence of this change in requirements.

Gap analysis on policies and procedures disclosed that the SOP titled '*Adult Consumers on Custodial orders at the Canberra Hospital* (*s 309* of the *Crimes Act 1900*)' addresses notification to the Magistrates Court when the patient is discharge but not if the patient is detained. [43] Although the SOP[44] states where a consumer is detained for an extended period of time, Forensic Services are to be informed it does not specifically address the detentions relating to up to 3 day authorisation by the doctor and the up to 7 day detention order by the ACAT.

Implication

The practice for ACT Heath to prepare a report on release of a person admitted under *section 309* is what occurs at the time of this audit. The requirements of the *Mental Health (Treatment and Care) Act 1994* to notify the Magistrates Court of the results of an examination or the reason for involuntary detention and care are not occurring. Apparently this is at the request of the Magistrates Court.

---

[42] Page 2 , Para 3, SOP 'Adult consumers on custodial orders at the Canberra Hospital-*s 309* of the *Crimes Act* –(Document number MHP-014)

[43] SOP-Adult Consumers on Custodial orders at the Canberra Hospital -Page 2, Para 13-"/ also para 15

[44] Adult Consumers on Custodial orders at the Canberra Hospital -Page 4, Para 19"

Recommendation 7

ACT Health to clarify the reports to go to the Magistrates Court. Document the agreement with the Magistrates Court and adhere to the agreed process for reporting.

Risk Rating

Medium

Responsible Officer
Chief Psychiatrist

Management comments
Agreed. Clarification has already occurred and the required reports are going to the Magistrates Court.

Implementation timeframe
August 2015

Releasing a person admitted under *section 309* of the *Crimes Act 1900*

There are two requirements at the time of release of a person admitted under *section 309* of the *Crimes Act 1900* –

- A report for the Magistrates Court; and
- for the person to be released into the custody of a police officer.

To prepare the report for the Magistrates Court, at the time of discharge, the doctor completes a proforma which is loaded on to Mhagic. The report goes to the Magistrates Court. Audit sighted completed reports for the Magistrates Court on Mhagic.

To coordinate the release of the person into the custody of a police officer the Australian Federal Police (AFP) is contacted. There's no requirement in the Act that the release to a police officer to be recorded. Documented information sighted from the sample testing included: Applications for transport sent to the watch house; reference to being handed over to the police on a future date; and a call from the watch house asking about medication. Despite the Act not having a specific request to record release into the custody of a police officer, in eight out of twelve cases there were notes relating to contact with the police. For two of these cases the file notes indicated the person was picked up by the police.

Included in the SOP –'Adult Consumers on Custodial Orders (*s309* of the *Crimes Act 1900*)' is a step by step process and the required information to be entered into Mhagic if the patient is released to AFP after an 'assessment'. The specific information to be entered into Mhagic is not included in the SOP's step by step instructions of releasing a person after an admission to the Adult Mental Health Unit.

Implication

Mhagic is what is currently being used by the 'Forensic Court Liaison Officers' to find out if a person has been admitted under *section 309* have been released. Therefore, it is important that Mhagic is completed by all areas of ACT Health to assist communication. The existing SOP should

be expanded to include specific information to be entered into Mhagic for releasing a person after admission of the Adult Mental Health Unit.

Recommendation 8

Forensic Mental Health Services in conjunction with Mental Health Assessment Unit and the Adult Mental Health Unit should complete the draft SOP 'Adult Consumers on Custodial Orders (*s 309 of the Crimes Act 1900*)' prior to having it approved, communicated and implemented.

Risk Rating

Medium

Responsible Officer
Chief Psychiatrist

Management comments

Agreed. Mental Health, Justice Health and Alcohol and Drug Services are working with HealthCARE Improvement Division with the intention of having SOPs updated and approved prior to November 2015 when the new Act commences.

Implementation timeframe
August 2015

Communicating release of a person under section 309 of the Crimes Act within ACT Health

Since the introduction of the *Mental Health (Treatment and Care) Act 1994*, the role of 'Tribunal Liaison Officer' has been created in addition to the existing role of the 'Court Liaison Officer'. These two roles are performed by different staff members. The current 'Tribunal Liaison Officer' used to be the 'Court Liaison Officer'. The 'Court Liaison Officer' is the title for one of the recipients of the created forms. Since the creation of the 'Tribunal Liaison Officer' these forms are sent to the 'Tribunal Liaison Officer' instead of to the 'Court Liaison Officer' for forwarding to the Public Advocate and the ACAT.

Implication

What has occurred as a result of this new 'Tribunal Liaison Officer' role is that the 'Court Liaison Officers' are no longer informed about the processes taken for people admitted under *section 309*. The 'Court Liaison Officer' role at present is supported by the Forensic Mental Health Services and is known as the 'Mental Health Court Liaison Officer' or the 'Forensic Court Liaison Officer'. The preferred process for enacting *section 309* of the *Crimes Act 1900* has been set out in a Mental Health Justice Health Alcohol and Drug Services Standard Operating Procedure titled '*Adult Consumers on Custodial Orders* (*section 309* of the *Crimes Act 1900*)' (SOP). At the time of this audit this SOP was overdue and being reviewed.

The SOP is being reviewed to improve the communication process between the Mental Health Court Liaison Officer, Consultant Psychiatrist, The Canberra Hospital Emergency Department/ Triage staff, Mental Health Assessment Unit staff and the Adult Mental Health Unit.

The SOP includes a step stating '*Where a consumer is to be detained for an extended period of time, Forensic Services are to be informed. This will enable Forensic Service to advise the Court that the person has been hospitalised and for the Court Liaison Officer to try and reschedule future court hearings.*' With the removal of informing the Court Liaison Officer or the Magistrates Court of the reason for detention and care or the results of the examinations the Court Liaison Officers now have to review Mhagic and the scheduled Court proceedings. Audit was informed that at times five minutes notice is given for the Court Liaison Officer to present at the courts when the patient is discharged.

Recommendation 9

Same as Recommendation 8.

Risk Rating

Medium

Responsible Officer
Chief Psychiatrist

Management comments
Agreed. Mental Health, Justice Health and Alcohol and Drug Services are working with HealthCARE Improvement Division with the intention of having SOPs updated and approved prior to November 2015 when the new Act commences.

Implementation timeframe
August 2015

4.3 Psychiatric Treatment Orders

Background for Psychiatric Treatment Orders

The Chief Psychiatrist is responsible for the treatment and care of a person to whom a Psychiatric Treatment Order applies.[45]

The Director of Clinical Services currently holds the Chief Psychiatrist role. The Chief Psychiatrist may, with the Minister of Health's approval, delegate the Chief Psychiatrist's functions under the *Mental Health (Treatment and Care) Act 1994* to a psychiatrist who is an employee or is engaged by the Territory.[46]

Psychiatric Treatment Orders are granted if the ACAT is satisfied that: a person has a mental illness; therefore the person may do serious harm to himself, herself or others; the Psychiatric Treatment Order is likely to reduce the harm or deterioration; and the treatment, care and support cannot be provided in an alternative way.[47]

An application is made to ACAT using the 'Mental Health Orders- Application Form'. This audit tested the: content of the Psychiatric Treatment Order[48]; role of the Chief Psychiatrist[49]; length of the Psychiatric Treatment Order[50]; ending the Psychiatric Treatment Orders if no longer appropriate[51]; and Register of involuntary restraint or seclusion[52]. The content and length of the Psychiatric Treatment Orders are the ACAT responsibilities.

Findings

The key controls for Psychiatric Treatment Orders are:

- the Application to ACAT for a Psychiatric Treatment Orders completed by the Doctor using the 'Mental Health Orders – Application Form';
- obtaining a witness for the person signing the 'Mental Health Orders – Application Form';
- delegations of the Chief Psychiatrist;
- maximum length of the Psychiatric Treatment Orders, 6 months; and
- the preparation and distribution of 'Treatment Plan and Location Determinations'.

An external key control for the Psychiatric Treatment Order is:

- The ACT Civil and Administrative Tribunal hearings to make, vary, review and revoke Orders.

---

45 Act reference Part 4 Division 4.4 section 32 (1)

46 Act reference Part 10 Section 118

47 Act reference Part 4 Division 4.4 Section 28

48 Act reference Part 4 Division 4.4 section 29 parts (1),(2) and (3)

49 Act reference Part 4 Division 4.4 section 32 parts (1),(2), (3), (4), (5), (6)

50 Act reference Part 4 Division 4.7 section 36J parts (1) (a) and (2)

51 Act reference Part 4 Division 4.4 section 34 part (1) an (2)

52 Act reference Part 4 Division 4.4 section 35 part (4)

The Role of the Chief Psychiatrist

One of the roles of the Chief Psychiatrist is to put in writing the times when and the place where the person on a Psychiatric Treatment Order is required to attend treatment care or support and the nature of the psychiatric treatment to be given to the person.[53] The Chief Psychiatrist must regard that the treatment will be beneficial.[54] This determination by the Chief Psychiatrist must be made within five working days of the Psychiatric Treatment Order being made.[55] As soon as practicable a copy of this determination must be given to the ACAT and the Public Advocate and if applicable a guardian or an attorney.[56] This is known as the Treatment Plan 'at discharge'.

To assist the Chief Psychiatrist meet this requirement a 'Treatment Plan and Location Determination' form has been created. This form states that the original is to be given to the Tribunal Liaison Officer who will notify the ACAT and the Public Advocate. Included in the form is a section to show that before making the determination the Chief Psychiatrist consulted: 1) the person; 2) the guardian and or 3) the attorney.

Psychiatric Treatment Orders are granted for a period of up to six months.[57]Therefore there are a number of 'Treatment Plan and Location Determination' forms prepared for each person subject to a Psychiatric Treatment Order. For example the first one could be prepared to show the Treatment Plan while the person is in the Canberra Hospital under an Emergency Detention Order. Another Treatment Plan would be required if the person is relocated to the Adult Mental Health Unit. Another Treatment Plan would be required if the person is transferred to another location for the duration of the Psychiatric Treatment Orders (this could be the person's home). There may also be occasions where the ACAT hearing will require changes to the 'Treatment Plan and Location Determination' form.

Audit was informed by the ACAT representatives that the obligation to provide a copy of the 'Treatment Plan and Location Determination' written within five days of the Psychiatric Treatment Order being made is only met in approximately one third of the cases.[58] Audit was also informed that the 'Treatment Plan and Location Determination' presented to the ACAT as part of evidence for the application for the Psychiatric Treatment Order is not the same as the 'Treatment Plan and Location Determination' for the care of a person for the duration of the Psychiatric Treatment Order.

The Public Advocate representatives informed audit they were receiving 'Treatment Plan and Location Determination' 'discharge' forms.

The SOP 'Care of Consumers subject to Psychiatric Treatment Orders (PTOs)' treats the Treatment Plan submitted for the application of a Psychiatric treatment Order and the treatment plan required after the Psychiatric Treatment Order as predominantly the same document. Under the heading 'PTO Application, ACAT Hearing, and Review Process' the SOP states:

---

53 Act reference Part 4 Division 4.4 Section 32 (2) (a) and (b)

54 Act reference Part 4 Division 4.4 section 32 (5)

55 Act reference Part 4 Division 4.4 section 32 (2)

56 Act reference Part 4 Division 4.4 section 32 (6)

57 Act reference Part 4 Division 4.7 Section 36 (j) (a)

58 Meeting with ACAT representatives 4 September 2014

1. *When making an application for a Psychiatric Treatment Order, (PTO), a written Treatment Plan must be submitted.*

2. *In the rare circumstances where a Treatment Plan is not submitted with the Assessment, it must be completed within 10 days of making of the PTO and a copy forwarded to the Tribunal Liaison Officer who will forward it to the ACT Civil Administrative Tribunal (ACAT) and the Public Advocate (as required by the Legislation)...*

Implication

The SOP, developed by ACT Health, and the ACAT seem to have a different approach to the Treatment Plan. Also the timing in the SOP of 10 days is not consistent with the 5 days required under the *Mental Health (Treatment and Care) Act 1994*.

The Chief Psychiatrist is not compliant, in all cases, with the *Mental Health (Treatment and Care) Act 1994* requirement to prepare a written 'Treatment Plan and Location Determination' within five working days of the Psychiatric Treatment Order being made and to provide a copy to the ACAT as soon as practicable.

Recommendation 10

i) ACT Health should incorporate the 'Treatment Plan and Location Determination' to be submitted for all assessments for a 'Psychiatric Treatment Order' or a 'Community Care Order'. Incorporate wording to show that if an order is made the 'Treatment Plan Location Determination' will be regarded as the determination written within 5 working days of Order being made;

ii) Incorporate the changes in 9 i) into Mhagic;

iii) Update the 'Care of Consumers subject to Psychiatric Treatment Orders (PTOs)' accordingly; and

iv) Distribute the 'Treatment Plan and Location Determination' to: the ACAT; the Public Advocate; and a guardian or an attorney if applicable.[59]

Risk Rating

Medium

Responsible Officer
Chief Psychiatrist

Management comments
Agreed. To assist streamline the process around 'Treatment Plan and Location Determinations' documentation will be updated and ACT Health will work with the ACAT. Incorporating the changes into Mhagic will only be fully aligned when the new Mental Health record replaces the current Mhagic. (10 ii))

Implementation timeframe
September 2015

---

[59] Act reference Part 4 Division 4.4 section 32 parts (2) and (6) and (7)

Delegations by the Chief Psychiatrist and corporate knowledge

Under the *Mental Health (Treatment and Care) Act 1994* the Chief Psychiatrist is able to delegate the Chief Psychiatrist's functions to a psychiatrist who is a public employee or is engaged by the Territory. [60]Audit was provided with a list of the current delegates.

The Tribunal Liaison Officers are not on the list of Chief Psychiatrist Delegates as they are not psychiatrists. However, the Tribunal Liaison Officers are responsible for carrying out many of the administrative tasks assigned to the Chief Psychiatrist. The Tribunal Liaison Officers are able to provide an overview of the ED3s, ED7s, Psychiatric Treatment Orders, when these are up for review and Electroconvulsive Therapy Orders.

These roles were created to be the liaison with the ACAT. The numbers of EDs, ED3s that didn't lead to the application for further detention up to 7 days and Psychiatric Treatment Orders for 2013 (See table on page 16) show that the equivalent of two ED3s a day are being admitted to approved health facilities. For each of these the Tribunal Liaison Officers need to get an indication from a doctor on if it is likely that the person is going to have an application for an ED7. This information has to be shared with the ACAT to coordinate a possible hearing time (within the three day detention period). If a person's circumstances change (who was thought not to require an ED7 and then does) this time is reduced further. The Public Advocate also receives all the documentation provided to the ACAT.

The Public Advocate staff work with the Tribunal Liaison Officers on a regular basis. The Public Advocate staff have seen the roles of the Tribunal Liaison Officers expand over time.

There is also the issue of what processes are to be followed if a person on an ED3 is moved from Emergency Department to another ward for medical treatment. In these incidences if Ward staff are not aware of the Involuntary Provision processes, or if the Tribunal Liaison Officer has not been informed, the timeframes may not be met.

The Chief Psychiatrist, Care Coordinator, Executive Officer and Manager, Mental Health Policy Unit are examples of other key staff holding the corporate knowledge of the *Mental Health (Treatment and Care) Act 1994*.

Implication

There is a great deal of the corporate knowledge of the *Mental Health (Treatment and Care) Act 1994* sitting with the Tribunal Liaison Officers and other key ACT Health staff which may be lost if these staff leave ACT Health.

Recommendation 11

i) The Chief Psychiatrist should ensure there are succession planning and knowledge management strategies for key ACT Health staff who hold the corporate knowledge of the *Mental Health (Treatment and Care) Act 1994*.

---

[60] Act reference Part 10 Section 118

ii) The Executive Director Policy and Government Relations should ensure succession planning and knowledge management strategies for ACT Health staff who hold the corporate knowledge of the *Mental Health (Treatment and Care) Act 1994*.

Risk Rating

Low

Responsible Officer
i) Chief Psychiatrist

ii) Executive Director Policy and Government Relations

Management comments
11 i) Agreed. Manuals are being prepared and the staffing arrangements currently in place assist with succession planning.
11ii) Agreed. The Mental Health Policy Unit is currently recruiting a mental health legal policy officer to ensure that the corporate knowledge regarding the Mental Health (Treatment and Care) Act 1994 that has been acquired through custom and practise is not lost. The new position will systematise the documentation of this knowledge.

Implementation timeframe
i) June 2016

ii) June 2016

Recommendation 12

ACT Health should ensure the ACT Health staff who will treat people on involuntary provisions are trained in areas of compliance for the *Mental Health (Treatment and Care) Amendment Act 2014*.

Risk Rating

High

Responsible Officer
Chief Psychiatrist

Management comments
Agreed. A staff member has been assigned to developing the training across ACT Health to be ready in November 2015 when the new Act commences.

Implementation timeframe
November 2015

4.4 Community Care Orders

Background for Community Care Orders

The Care Coordinator is responsible for coordinating the provision of treatment, care and support for a person to whom a Community Care Order applies.[61]

The Executive Director, Rehabilitation, Aged and Community Care, currently holds the Care Coordinator role. Therefore, this position is held within ACT Health at the time of the audit. The role of Care Coordinator is not assigned to a specific Directorate within the ACT Government, as the Agency it was assigned to when the Act was created in 1994, no longer exists.

In April 2014, the Executive Officer role, for the Care Coordinator, returned to the Public Advocate. This role was transferred to ACT Health's Manager Mental Health Policy Unit, between the Senior Advocate's appointments.

Community Care Orders are granted if ACAT are satisfied that: a person is mentally dysfunctional; the person may do serious harm to himself, herself or others; the treatment, care and support is likely to reduce the harm; a Psychiatric Treatment Order should not be made; and the treatment, care and support cannot be provided in an alternative way.[62]

An application is made to ACAT using the 'Mental Health Orders- Application Form'. This audit tested the: content of the Community Care Order[63]; role of the Care Coordinator[64]; length of the Community Care Order[65]; ending the Community Care Orders if no longer appropriate[66]; and Register of involuntary restraint, seclusion or administration of medication[67].

Findings

Register of involuntary restraint, seclusion or administration of medication

Section 36G part 5 (c) of the *Mental Health (Treatment and Care) Act 1994* requires that a register to be maintained for the Involuntary restraint, seclusion or administration of medication to record additional levels of restraint, seclusion or administration of medication than would usually occur under the Community Care or Restriction Order. The Care Coordinator delegates the coordination of care providers, to an individual requiring care, under a Community Care Order. The delegate must be an individual working for part of ACT government. The locations of people on Community Care Orders spreads across ACT. Some of them may be in ACT Health facilities at some points in time. Some of the people on Community Care Orders have disabilities. The National Disability

---

61 Act reference Part 4 Division 4.5 section 36D (1)

62 Act reference Part 44 Division 4.5 section 36 parts (a), (b), (c), (d) and (e)

63 Act reference Part 4 Division 4.5 section 36A parts (1) and (3)

64 Act reference Part 4 Division 4.5 section 36A parts ((4) and (5)

65 Act reference Part 4 Division 4.7 section 36J parts (1) (a) and (2)

66 Act reference Part 4 Division 4.5 section 36F part (1) an (2)

67 Act reference Part 4 Division 4.5 section 36G part (5) (c)

Insurance Scheme (NDIS), a new way of funding individualised support for people with a disability commenced on 1 July 2014, with an expected two year roll out. The NDIS roll out may have an impact on Disabilities ACT.[68] Disabilities ACT is the service provider currently working with some of the people on Community Care Orders.

Audit noted that currently there is no 'Register of involuntary restraint, seclusion or administration of medication' for people on Community Care Orders as required. Audit was informed that in five years there has not been any incident that required recording in a register in relation to a person on a Community Care Order.

The Amendment Act requires a person subjected to involuntary seclusion to be examined by a relevant doctor at least once in each 4 hour period for which the person is in seclusion.[69]

Implication

The practicality of having the register, due to the nature of a Community Care Order, should be given consideration. Audit was informed that the staff in aged care facilities would not be trained in, or want to, 'restrain, seclude or forcefully give medication'. Therefore it would be anticipated that the person would be taken to a health facility. It would therefore be worth considering combining the registers required for the Chief Psychiatrist and the Care Coordinator under the Act.

In the Amendment Act both registers now require the three components; restraint, seclusion and administration of medication. The wording in the Amendment Bill has been improved to show that it is 'forcibly given medication' that is expected to go into the Register, not just routine administration of medication.

The Amendment Act now requires the Public Advocate be notified of any restraint, seclusion or forcible administration of medication within 12 hours, instead of 24 hours.

As there was no register in place for the Care Coordinator it was not possible to test if the Public Advocate was being notified in the required timeframe.

The new requirements around reporting and treatment and care will require staff training and clear communication channels internally and externally. To assist staff on the job to comply with the new Amendment Act the Register should have cues, like columns in the register for types of orders. With the new Amendment Act there are now the following types of orders:

- Psychiatric Treatment Orders
- Community Care Orders
- Restriction Orders
- Forensic Psychiatric Treatment Orders
- Forensic Community Care Orders
- Electroconvulsive Therapy Orders (Requires a separate register covered in Section 3.6)

---

[68] http://www.communityservices.act.gov.au/disability_act/national_disability_insurance_scheme

[69] Amendment Bill 2014reference, page 59 36ZC Powers in relation to psychiatric treatment order (3)

Recommendation 13

ACT Health should consider combining the registers required for the Chief Psychiatrist and the Care Coordinator to record restraint, seclusion and forceful administration of medication. Ensure the Register(s) has a column to indicate whether the restraint, seclusion or forceful administration of medication has been under the delegation of the Chief Psychiatrist or the Care Coordinator and another column to indicate which type of order the person is on.

Risk Rating
Medium

Responsible Officer
Chief Psychiatrist

Management comments
Agreed. There is currently inter-Divisional work going on in the area of Restraint.

Implementation timeframe
November 2015

Treatment and updating Care Coordinator SOPS

As discussed in Section 4.1, recommendation 5 all SOPs should be updated to reflect the *Mental Health (Treatment and Care) Amendment Act 2014*. SOPs relating to the Care Coordinator should also be updated. However, there is the added complication with the Executive Officer role with the Public Advocate's Office that policy and procedures are written and approved within the Justice Community Safety Directorate (JACS). With the Care Coordinator working in ACT Health it has been suggested that the Executive Officer policy and procedure documents be adopted and approved by ACT Health and JACS.

This recommendation is made on the condition that the Executive Officer for the Care Coordinator role still exists. In May 2015 audit was informed that ACT Health and JACS were in discussion about the future role of the Care Coordinator.

Recommendation 14
ACT Health and Justice Community Safety Directorate should review the future processes of the Care Coordinator role. If applicable, ACT Health and the Executive Officer for the Care Coordinator should develop a process to have policies and procedures for the Care Coordinator Executive Officer role be approved and adopted for both JACS and ACT Health.
Risk Rating
Low

Responsible Officer
Executive Director, Policy and Government Relations in consultation with the Care Coordinator
Management comments
Agreed. ACT and Justice Community Safety Directorate should agree on the future support and processes for the Care Coordinator Role. Further examination is required to clarify if policies and procedures used for the Care Coordination Executive Officer role should be approved and adopted for both JACS and ACT Health as the Community Care Coordinator is a Statutory Officer.
Implementation timeframe
June 2016

4.5 Restriction Orders

Background for Restriction Orders

Restriction Orders can only be made if there is a Psychiatric Treatment Order or a Community Care Order in place. The Restriction Order states where a person must live (but not be detained) or the community care facility where the person is to be detained. Restriction Orders must be for three months or less.[70]

All the Restriction Orders granted in 2013 were attached to Community Care Orders. An application for Restriction Orders is made to the ACAT using the 'Mental Health Orders Application Form'

This audit tested: Was there a Psychiatric Treatment Order or Community Care Order with the Restriction Order; and the length of the Restriction Orders. The content of the Restriction Order and ACAT requirements were also tested, but both of these are ACAT compliance matters.

Findings

The key controls for Restriction Orders are:

- Making an application to the ACAT for a Restriction Order;
- Attaching a Restriction Order to a Psychiatric Treatment Order or a Community Care Order;
- Making a Restriction Order for 3 months or less;
- Reviewing Restriction Orders.

The data provided to Audit regarding Restriction Orders indicated that in 2013 there were ten people on Restriction Orders. Of the ten people on Restriction Orders: some were granted new Restriction Orders created from Emergency Detentions; others had Restriction Orders granted at ACAT hearings and others had their Restriction Orders reviewed (on at least one occasion).

All the Restriction Orders testing showed that each Restriction Order had a corresponding Community Care Order. All Restriction Orders were 3 months or less.

The folders provided for Restriction Order and Community Care Order testing were not complete. However, as the role of Executive Officer to support the Care Coordinator was transferred outside ACT Health in April 2014 this is not an audit finding.

[70] Act reference Part 4 Division 4.7 section 36J sections 1)(b) and (2)

4.6 Electroconvulsive Therapy Orders

Background for Electroconvulsive Therapy Orders

Electroconvulsive therapy means a procedure for the induction of an epileptiform convulsion in a person.[71] For Electroconvulsive Therapy Order to be granted there must be a Psychiatric Treatment Order in place.[72] Applications for Electroconvulsive Therapy Orders are to be supported by evidence from another psychiatrist, a second opinion.[73]Under each Electroconvulsive Therapy Order, up to nine treatments can be administered.[74]The records of Electroconvulsive Therapy given must be kept for at least five years after the day the record is given.[75]

Findings

The key controls for Electroconvulsive Therapy Orders are:

- The person in charge of the psychiatric institutions keeping records of electroconvulsive therapy given for at least five years[76];
- The doctor who administers the Electroconvulsive Therapy must make a record of the treatment and give it to the person in charge of the psychiatric institution where the treatment occurs [77];
- the Application to ACAT for a Electroconvulsive Therapy 'Orders' completed by the Doctor using the 'Mental Health Orders – Application Form';
- obtaining a witness for the person signing the 'Mental Health Orders – Application Form';
- A second opinion on Electroconvulsive Therapy being provided by another psychiatrist[78];

Electroconvulsive Therapy Register at the Adult Mental Health Unit

The requirement for the person in charge of the psychiatric institution to keep records of Electroconvulsive Therapy Treatments for 5 years is being met[79]. However, there were incidences where the lines in the ECT Register were left blank, hence the record is not complete. In the Register each treatment for an individual receiving Electroconvulsive Therapy is numbered (to assist monitor that not over nine treatments are administered with one Electroconvulsive Therapy Order). One example is there were six blank lines underneath an entry for a particular person. The

---

[71] Act reference Part 7 subdivision 7.2 part 55.

[72] Act reference Part 7 subdivision 7.2.3 section 55E

[73] Act reference Part 7 subsection 7.2.3 Section 55F part (2) (e)

[74] Act reference Part 7 subdivision 7.2.3 section 55J

[75] Act reference Part 7 subdivision 7.2.3 section 58

[76] Act reference Part 7 subdivision 7.2.6 section 58

[77] Act reference Part 7 subdivision 7.2.6 section 57

[78] Act reference Part 7 subsection 7.2.3 Section 55F part (2) (e)

[79] Act Reference Part 7 Subsection 7.2.6 section 58

way the treatments were numbered showed treatment two was recorded. Six blank lines later the next treatment recorded was treatment number nine.[80]

The register itself is a self bound document with pages falling out. Sticky tape has been used to keep pages with the document. The content of the register contained inconsistencies. The Electroconvulsive Therapy Register lacked the professional appearance of a legal document.

Implication

Section 57 of the *Mental Health (Treatment and Care) Act 1994* has penalties for doctors who commit an offence by not recording Electroconvulsive Therapies. Section 58 of the *Mental Health (Treatment and Care) Act 1994* has penalties for the person in charge of the psychiatric institution if the record of Electroconvulsive Therapy is not kept for at least 5 years. Therefore, as the Electroconvulsive Therapy Register is not complete the administering doctor and the person in charge of the psychiatric institution appear to be committing an offence.

Recommendation 15

ACT Health should upgrade the Electroconvulsive Therapy Register to a bound book with numbered pages. Ensure all Electroconvulsive Therapy Treatments are recorded consistently in the Register.

Risk Rating

Medium

Responsible Officer
Chief Psychiatrist

Management comments
Agreed. A bound book will be adopted while consideration is being given to adopting an electronic Electroconvulsive Therapy Register.

Implementation timeframe
August 2015

[80] 'Extract of the ECT Register 6 June 2014' Q drive location: Internal Audit Reports/2014/Internal Audit of Compliance with Mental Health Provisions/ Testing

Appendix A Action sheet

Area Audited:	Internal Audit of Compliance with Mental Health Act Involuntary Provisions
Date of Audit:	June to October 2014

	Audit Recommendation	Management Comment	Estimated Completion Date	Action Officer
1	ACT Health should prepare a timeline and establish monitoring processes to support the Minister's requirements to report on up to eleven day detention and five aspects of Orders.	Agreed. Records will continue to be maintained to assist reporting on the number of Orders resulting from 11 day detentions, for comparison with existing records.	September 2015	Chief Psychiatrist
2	Train ACT Health staff who work with intoxicated people brought to the Emergency Department to assist them understand 'duty of care' under common law principles and when Emergency Detention may apply.	Agreed. A staff member has been assigned to developing the training across ACT Health to be ready in November 2015 when the new Act commences.	November 2015	Chief Psychiatrist
3	ACT Health should clarify delegations for the person in charge of the mental health facility and the Chief Psychiatrist relating to notifications required if an initial examination has not occurred within four hours. Include this information in the relevant Standard Operating Procedure (SOP).	Agreed. Policy and Government Relations will work closely with the Chief Psychiatrist and the Deputy Director General of the Canberra Hospital & Health Services to develop a Standard Operating Procedure clarify delegations for the person in charge of the mental health facility and the Chief Psychiatrist relating to notifications required if an initial examination has not occurred within four hours. The SOP will be finalised prior to prior to the new ACT Mental Health Act becoming operational 12 November 2015.	September 2015	Executive Director Policy and Government Relations

4	Clarify the working relations between the Chief Psychiatrist, psychiatrists in private practice and community sector organisations.	Agreed. Policy and Government Relations will work closely with the Chief Psychiatrist to clarify the working relations between the Chief Psychiatrist, psychiatrists in private practice and community sector organisations under the new Mental Health Act prior to the new Act becoming operational 12 November 2015.	September 2015	Executive Director Policy and Government Relations
5	Update all SOPs used to support compliance with the *Mental Health (Treatment and Care) Act 1994* to reflect the new Amendment Act.	Agreed. Mental Health, Justice Health and Alcohol and Drug Services are working with HealthCARE Improvement Division with the intention of having SOPs updated and approved prior to November 2015 when the new Act commences.	September 2015	Chief Psychiatrist
6	ACT Health should update the forms used to support compliance with the *Mental Health (Treatment and Care) Act 1994* to reflect the new Amendment Bill. Ensure the 'Statement of Action' includes a space for the date and time of admission to a health facility and all forms encompass the current titles and clear and consistent naming conventions.	Agreed. Updated forms will assist meet compliance with the Mental Health (Treatment and Care) Amendment Act 2014.	September 2015	Chief Psychiatrist
7	ACT Health should clarify the reports to go to the Magistrates Court. Document the agreement with the Magistrates Court and adhere to the agreed process for reporting.	Agreed. Clarification has already occurred and the required reports are going to the Magistrates Court.	August 2015	Chief Psychiatrist

8	Forensic Mental Health Services in conjunction with Mental Health Assessment Unit and the Adult Mental Health Unit should complete the draft SOP 'Adult Consumers on Custodial Orders (s 309 of the Crimes Act 1900)' prior to having it approved, communicated and implemented.	Agreed. Mental Health, Justice Health and Alcohol and Drug Services are working with HealthCARE Improvement Division with the intention of having SOPs updated and approved prior to November 2015 when the new Act commences.	August 2015	Chief Psychiatrist
9	Same as Recommendation 8.	Agreed. Mental Health, Justice Health and Alcohol and Drug Services are working with HealthCARE Improvement Division with the intention of having SOPs updated and approved prior to November 2015 when the new Act commences.	August 2015	Chief Psychiatrist
10	i) ACT Health should incorporate the 'Treatment Plan and Location Determination' to be submitted for all assessments for a 'Psychiatric Treatment Order' or a 'Community Care Order'. Incorporate wording to show that if an order is made the 'Treatment Plan Location Determination' will be regarded as the determination written within 5 working days of Order being made; ii) Incorporate the changes in 9 i) into Mhagic; iii) Update the 'Care of Consumers subject to Psychiatric Treatment Orders (PTOs)' accordingly; and iv) Distribute the 'Treatment Plan and Location Determination' to: the ACAT; the Public Advocate; and a guardian or an attorney if applicable.	Agreed. To assist streamline the process around 'Treatment Plan and Location Determinations' documentation will be updated and ACT Health will work with the ACAT. Incorporating the changes into Mhagic will only be aligned when the new Mental Health record replaces the current Mhagic. (10 ii))	September 2015	Chief Psychiatrist

	Audit Recommendation	Management Comment	Estimated Completion Date	Action Officer
11	i) The Chief Psychiatrist should ensure there are succession planning and knowledge management strategies for key ACT Health staff who hold the corporate knowledge of the *Mental Health (Treatment and Care) Act 1994*. ii) The Executive Director Policy and Government Relations should ensure succession planning and knowledge management strategies for ACT Health staff who hold the corporate knowledge of the *Mental Health (Treatment and Care) Act 1994*.	11 i) Agreed. Manuals are being prepared and the staffing arrangements currently in place assist with succession planning. 11 ii) Agreed. The Mental Health Policy Unit is currently recruiting a mental health legal policy officer to ensure that the corporate knowledge regarding the Mental Health (Treatment and Care) Act 1994 that has been acquired through custom and practise is not lost. The new position will systematise the documentation of this knowledge.	i) June 2016 ii) June 2016	i) Chief Psychiatrist ii) Executive Director Policy and Government Relations
12	ACT Health should ensure the ACT Health staff who will treat people on involuntary provisions are trained in areas of compliance for the *Mental Health (Treatment and Care) Amendment Act 2014*.	Agreed. A staff member has been assigned to developing the training across ACT Health to be ready in November 2015 when the new Act commences.	November 2015	Chief Psychiatrist
13	ACT Health should consider combining the registers required for the Chief Psychiatrist and the Care Coordinator to record restraint, seclusion and forceful administration of medication. Ensure the Register(s) has a column to indicate whether the restraint, seclusion or forceful administration of medication has been under the delegation of the Chief Psychiatrist or the Care Coordinator and another column to indicate which type of order the person is on.	Agreed. There is currently inter-Divisional work going on in the area of Restraint.	November 2015	Chief Psychiatrist
14	ACT Health and Justice Community Safety Directorate should review the future processes of the Care Coordinator role. If applicable, ACT Health and the Executive Officer for the Care Coordinator should develop a process to have policies and procedures for the Care Coordinator	Agreed. ACT and Justice Community Safety Directorate should agree on the future support and processes for the Care Coordinator Role. Further examination is required to clarify if policies and procedures	June 2016	Executive Director, Policy and Government Relations in consultation with the Care Coordinator

	Audit Recommendation	Management Comment	Estimated Completion Date	Action Officer
	Executive Officer role be approved and adopted for both JACS and ACT Health.	used for the Care Coordination Executive Officer role should be approved and adopted for both JACS and ACT Health as the Community Care Coordinator is a Statutory Officer.		
15	ACT Health should upgrade the Electroconvulsive Therapy Register to a bound book with numbered pages. Ensure all Electroconvulsive Therapy Treatments are recorded consistently in the Register.	Agreed. A bound book will be adopted while consideration is being given to adopting an electronic Electroconvulsive Therapy Register.	August 2015	Chief Psychiatrist

Appendix B Personnel Consulted

The following ACT Health personnel, and others, were consulted as part of this audit. We are appreciative of their assistance.

- Tina Bracher, Mental Health, Justice Health and Alcohol and Drug Services
- Linda Kohlhagen, Executive Director, Rehabilitation, Aged and Community Care – Care Coordinator
- Dr Peter Norrie, Chief Psychiatrist
- Ross O'Donoughue, Executive Director Policy and Government Relations
- Richard Bromhead, Manager Mental Health Policy Unit
- Sharon Steele, Tribunal Liaison Officer
- Debbie Suitor, Tribunal Liaison Assistant
- Monique Fielder, Clinical Nurse Consultant
- Jessica Minchin, Court Liaison Officer
- Daniel Gleeson, Court Liaison Officer
- Bill Bailey, CNC – Registered Mental Health Nurse
- Dr Rodney Blanch - Registrar
- Linda Crebbin, ACAT Presidential Member
- Sarah Dupe, Team Leader Deputy Registrar Mental Health and Guardianship
- Patricia Mackey, Principal Advocate
- Christina Thompson , Senior Advocate, Mental Health and Forensic
- Denise Caldwell, Senior Advocate – Complex Disabilities, Executive Officer MAP and CCO

Appendix C Amendment Bill – Changes to the *Mental Health (Treatment and Care) Act 1994*

At the time of this audit there is an Amendment Bill for the *Mental Health (Treatment and Care) Act 1994* being debated in the Legislative Assembly. On the 30 October 2014 the Amendment Bill was passed without any changes. The Amendment Bill is available on the ACT Legislation website (www.legislation.act.gov.au). As the Amendment Bill was not passed while this audit was underway the terms and sections referred to in this audit relate to the 1994 Act. The *Mental Health (Treatment and Care) Amendment Act 2014* will commence in November 2015. A summary of the changes resulting from the Amendment Bill include[81]:

- Introducing the 'recovery' concept around people with Mental Illness. The review promotes recovery-oriented services of those that enable people to self-determine what constitutes a satisfying life for them, even though they may have ongoing symptoms of mental illness or disorders. The changes also intend for ACT mental health services to become recovery-oriented ones;
- Renaming 'mental dysfunctional' to 'mental disorder'. Mental dysfunctional is the term related to Community Care Orders;
- Revising the Objectives of the Act including; the promotion of people with mental disorder or mental illness to participate in their assessment and treatment, care or support; Information is to be provided to the person in a timely manner; and it will be assumed that the person has decision making capacity until it is established that the person has no decision making capacity. The review puts a great deal of emphasis on decision making capacity;

Additional requirements in the *Mental Health (Treatment and Care) Amendment Act 2014* include:

- that the initial examination, for someone in Emergency Detention, by the doctor must be 'in person'[82] and the subsequent physical examination by a doctor **and** a psychiatrist must be 'thorough'[83]. The current SOP[84] reflects section 43, revised in 1999, to provide '*that both a physical and psychiatric examination is completed within 24 hours for every person detained under emergency detention provisions, without providing that a psychiatrist must perform both examinations. In practice, a medical officer or registrar performs the physical examination leaving the specialist psychiatric consultant to attend to his or her core responsibilities for the psychiatric examination. This process is considered best practice as well as being the best use of available resources.*'[85] These two approaches are not consistent and will need to be addressed now the Amendment Bill was passed.

---

81 This is not a complete list of the changes from the Amendment Act 2014

82 Amendment Bill 2014 reference page 81 40 Initial examination at approved mental health facility (7) (a)

83 Amendment Bill 2014 reference page 82 41AA Medical examination of a detained person (1) (a) and (b)

84 Psychiatric and Medical Examination of Involuntary Consumers under the *Mental Health (Treatment and Care) Act 1994*

85 CHHS13/590 page 3, Psychiatric and Medical Examination of Involuntary Consumers under the *Mental Health (Treatment and Care) Act 1994*

- Adding an additional two hours to perform the initial examination of a person under Emergency Detention is not performed within four hours.[86] If this occurs there is an added requirement that the person in charge of the health facility contact the Chief Psychiatrist at the four hour point and ensure the examination occurs within the next two hours.

- Specifying criteria to detain a person if the initial four hour medical examination has not occurred.[87]

- notifying the Public Advocate of the following:

    - If a person has not been examined by a doctor within the first four hours of being involuntarily detained under Emergency Detention and the reason for the failure[88];

    - When a person has been subjected to confinement or restraint, involuntary seclusion or forcible giving of medication. The Chief Psychiatrist or the Care Coordinator needs to provide this in writing within 12 hours of it occurring.[89] [90]

- Enabling authorised paramedics to apprehend a person. It the current Act a police officer, a doctor or a psychiatrist are the professions able to apprehend a person and take them to an approved health facility;

- Involuntary detention of a person for 7 days or less has been extended to 11 days or less. Therefore now a person may be detained for a period up to fourteen days (up to 3 days authorised by a doctor and up to 11 days ordered by the ACAT). As this is being trialled, a report will have to be written within two and a half years of it being introduced to consider whether the intended benefit on course of treatment improved the person's experience of care;

- Where a person on a Psychiatric Treatment Order or a Community Care Order has been put into involuntary seclusion a relevant doctor must examine the person at least once in each 4 hour period for which the person is in seclusion.[91] [92]

- Expanding out the area relating to section *309* of the *Crimes Act* under 'Forensic mental health orders'. This is broader than just *section 309*, but is very similar. For Forensic mental health orders the measure will not be decision making capacity, but rather refusing to accept treatment. There is also a new measure to formally recognise people accused of a federal offence found unfit to plead and/or acquitted because of a mental illness;

- Addressing the transfer of certain detainees with a mental illness from a correctional centre to an approved health facility. This section applies to people with a mental illness for whom

---

86 Amendment Bill 2014 reference page 79 40 Initial examination at approved mental health facility 4 (a) and (b)

87 Amendment Bill 2014 reference page 80 40 Initial examination at approved mental health facility (3) (a), (b) and (c)

88 Amendment Bill 2014 reference page 80 40 Initial examination at approved mental health facility (6)

89 Amendment Bill 2014 reference page 59, 36ZC Powers in relation to psychiatric treatment order, (5)

90 Amendment Bill 2014 reference page 68 36ZK Powers in relation to community care order (5) (b)

91 Amendment Bill 2014reference, page 59 36ZC Powers in relation to psychiatric treatment order (3)

92 Amendment Bill 2014 reference page 68 36ZK Powers in relation to community care order (3)

a mental health order or a forensic health order cannot be made. It will provide a legal classification for detainees whilst being transferred;

The Amendment Bill attempted to ensure requirements from *The Human Rights Act 2004*, International Human Rights and United Nations Conventions on the Rights of People with Disabilities are being addressed in the *Mental Health (Treatment and Care) Amendment Act 2014*.

Appendix D Risk Rating Framework

CONSEQUENCE

	Insignificant	Minor	Moderate	Major	Catastrophic
People (Staff,Patients,Client , Contractors, OH&S)	Injuries or ailments not requiring medical treatment	Minor injury or First Aid Treatment required	Serious injury causing hospitalisation or multiple medical treatment cases.	Life threatening injury or multiple serious injuries causing hospitalisation.	Death or multiple life threatening injuries.
Clinical	• No injury • No review required • No increased level of care	Minor injury requiring: • Review and evaluation • Additional observations • First aid treatment	Temporary loss of function (sensory, motor, physiological or intellectual) unrelated to the natural course of the underlying illness and differing from the expected outcome of patient management.	Permanent loss of function (sensory, motor, physiological or intellectual) unrelated to the natural course of the underlying illness and differing from the expected outcome of patient management. A number of key events or incidents.	Patient death unrelated to the natural course of the underlying illness and differing from the immediate expected outcome of the patient management. All national sentinel events.
Property and Services (Business services and continuity)	• Minimal or no destruction or damage to property. • No loss of service • Event that may have resulted in the disruption of services but did not on this occasion.	• Destruction or damage to property requiring some unbudgeted expenditure. • Closure or disruption of a service for less than 4 hours- managed by alternative routine procedures. • Reduced efficiency or disruption of some aspects of an essential service.	• Destruction or damage to property requiring minor unbudgeted expenditure. • Disruption to one service or department for 4 to 24 hours - managed by alternative routine procedures • Cancellation of appointments or admissions for number of patients. • Cancellation of surgery or procedure more than twice for one patient.	• Destruction or damage to property requiring major unbudgeted expenditure. • Major damage to one or more services or departments affecting the whole facility – unable to be managed by alternative routine procedures. • Service evacuation causing disruption of greater than 24 hours, e.g. Fire/ flood requiring evacuation of staff and patients/clients (no injury); or Bomb threat procedure activation, potential bomb identified, partial or full evacuation required (+/- injury).	• Destruction or damage to property requiring significant unbudgeted expenditure. • Loss of an essential service resulting in shut down of a service unit or facility. • Disaster plan activation.
Financial	1% of budget or <$5K	2.5% of budget or <$50K.	5% of budget or <$500K.	10% of budget or <$5M.	25% of budget or >$5M.
Information	Interruption to records / data access less than ½ day.	Interruption to records / data access ½ to 1day	Significant interruption (but not permanent loss) to data / records access, lasting 1 day to 1 week.	Complete, permanent loss of some ACT Health or Divisional records and / or data, or loss of access greater than 1 week.	Complete, permanent loss of all ACT Health or Divisional records and data.

Business Process and Systems	Minor errors in systems or processes requiring corrective action, or minor delay without impact on overall schedule.	Policy procedural rule occasionally not met or services do not fully meet needs.	One or more key accountability requirements not met. Inconvenient but not client welfare threatening.	Strategies not consistent with Government's agenda. Trends show service is degraded.	Critical system failure, bad policy advice or ongoing non-compliance. Business severely affected.
Reputation	Internal review.	Scrutiny required by internal committees or internal audit to prevent escalation.	Scrutiny required by external committees or ACT Auditor General's Office or inquest, etc.	Intense public, political and media scrutiny e.g. front page headlines, TV stories, etc.	Assembly inquiry or Commission of inquiry or adverse national media.
Environment Broadly defined as the surroundings in which ACT Health operates, including air, water, land, natural resources, flora, fauna, humans and their interrelation.	Some minor adverse effects to few species / ecosystem parts that are short term and immediately reversible.	Slight, quickly reversible damage to few species / ecosystem parts, animals forced to change living patterns, full, natural range of plants unable to grow, air quality creates local nuisance, water pollution exceeds background limits for short period.	Temporary, reversible damage, loss of habitat and migration of animal population, plants unable to survive, air quality constitutes potential long term health hazard, potential for damage to aquatic life, pollution requires physical removal, land contamination localised and can be quickly remediated.	Death of individual people / animals, large scale injury, loss of keystone species and habitat destruction, air quality 'safe haven' / evacuation decision, remediation of contaminated soil only possible by long term programme, e.g. off-site toxic release requiring assistance of emergency services.	Death of people / animals in large numbers, destruction of flora species, air quality requires evacuation, permanent and wide spread land contamination, e.g. caused by toxic release on-site; chemical, biological or radiological spillage or release on-site.

LIKELIHOOD

Descriptor	Probability of occurrence	Indicative Frequency
Almost certain	Occurs more frequently than 1 in 10 tasks.	Is expected to occur in most circumstances.
Likely	1 in 10 – 100	Will probably occur.
Possible	1 in 100 – 1,000	Might occur at some time in the future.
Unlikely	1 in 1,000 – 10,000	Could occur but doubtful.
Rare	1 in 10,000 – 100,000	May occur but only in exceptional circumstances.

RISK MATRIX

Likelihood			Consequence →				
			Insignificant	Minor	Moderate	Major	Catastrophic
			1	2	3	4	5
↑	5	Almost Certain	Medium (11)	High (16)	High (20)	Extreme (23)	Extreme (25)
	4	Likely	Medium (7)	Medium (12)	High (17)	High (21)	Extreme (24)
	3	Possible	Low (4)	Medium (8)	Medium (13)	High (18)	Extreme (22)
	2	Unlikely	Low (2)	Medium (5)	Medium (9)	High (14)	High (19)
↑	1	Rare	Low (1)	Low (3)	Medium (6)	Medium (10)	High (15)

ACT Government
Health

Assessment of ACT Health's framework to manage staff misconduct and workplace issues

V_January 2015

Table of contents

Review timeframes

Task	Date	Reason for delay (if relevant)
Draft 'Request for Service' sent to IA&RM	31 October 2014	
IA&RM approve 'Request for Service'	3 November 2014	
Draft 'Terms of Reference' to IA&RM	5 November 2014	
Scoping / Entry Meeting	11 November 2014	
Revised 'Terms of Reference' to IA&RM	12 November 2014	
Final approval of 'Terms of Reference' (Planning completion)	18 November 2014	
Fieldwork commencement	20 November 2014	
Fieldwork completion	19 December 2014	
Draft discussion paper to IA&RM	16 January 2015 9 February 2015 1 April 2015	
Draft discussion paper to key stakeholders	8 April 2015	
Preliminary findings discussions	1 May 2015	
Exit meeting	26 June 2015	
Draft report to IA&RM	10 August 2015	
Final draft report received with management comments	27 October 2015	
Final signed report provided to ACT Health (Report completion)	27 October 2015	
Final report to the Executive Council		
Final report to Audit and Risk Management Committee		

1 Executive summary

1.1 Introduction

Deloitte has been engaged by the ACT Health Directorate (ACT Health) to conduct this engagement as part of the 2015 Strategic Internal Audit Plan. Included in this plan is an assessment of ACT Health's framework to manage staff misconduct and workplace issues. The assessment includes evaluation of the current framework for managing staff misconduct allegations against relevant legislation, agreements and better practice.

1.2 Background

ACT Health is an ACT Government Directorate responsible for delivering patient and family-centred health care, strengthening health partnerships, promoting good health and well-being, improving access to appropriate health care and having robust safety and quality systems.

The ACT Health Code of Conduct states that "The behaviour that ACT Health expects of its employees includes honesty, respect, confidentiality, professionalism and fairness." ACT Health has in place a process for the management of allegations of staff misconduct including the ACT Public Service Code of Conduct, ACT Public Service Integrity Policy and the ACT Health Public Interest Disclosure Policy and Procedures.

1.3 Review objectives

In accordance with our Terms of Reference dated 18 November 2014, we have completed an assessment of ACT Health's framework for the management of allegations of staff misconduct. In undertaking our assessment, analysis was performed using currently available information and included:

- Assessing the framework under which allegations of staff misconduct are managed against relevant legislation, regulations, agreements and better practice; and
- Analysing the processes and procedures for managing allegations of staff misconduct against better practice.

A copy of the approved objectives, scope and approach for the review are included within this report at Appendix H.

1.4 Overall observations

From the legislation, regulations, agreements and better practice identified in the Terms of Reference, and from references made within these identified documents, we identified a number of documents relevant to our engagement (please refer to sections 3.1 and 3.2). These include:

- Documents that ACT Health must comply with (such as legislation, regulations and enterprise agreements) have been identified in our report as "relevant compliance sources"; and
- Documents that represent practices ACT Health should consider adopting (such as ACTPS policies and guidelines) have been identified in our report as "better practice".

Based on a thorough assessment of ACT Health's policies, procedures and guidelines against relevant compliance sources and better practice we have identified ACT Health has a robust process in place for managing allegations of staff misconduct. This assessment was validated by undertaking a walkthrough to discuss the current processes and procedures with key ACT Health stakeholders.

ACT Health's framework for managing allegations of staff misconduct broadly aligns with relevant compliance sources and better practice; however we have identified 62 areas of potential improvement in ACT Health's framework for managing allegations of staff misconduct. ACT Health should assess these 62 areas of potential improvement to see whether including them in the Framework of ACT Health's policies, procedures and guidelines is beneficial (please refer to Appendices C, D, E and F for our detailed observations).

1.5 Summary of key findings

Report Section	Findings	Risk Rating	Recommendations
4	ACT Health is not updating its policies, procedures and guidelines promptly as relevant compliance sources change due to the introduction, amendment, succession or cessation of these sources over time.	Low	**1)** ACT Health should update the identified policies, procedures and guidelines to reflect relevant compliance sources for ACT Health
4	ACT Health's policies, procedures and guidelines do not consistently repeat the appropriate requirements of compliance sources relating to: • Communication with involved parties; • Liaison and referrals; • Investigative procedures; and • Management of disciplinary actions.	Low	Same as Recommendation 1

2 Management sign off

This report has been reviewed and discussed with management of the ACT Health Directorate. Management has had the opportunity to express any comments on the findings and recommendations outlined in this report.

Kim Smith
Deputy Director-General, Strategy and Corporate
ACT Health

30/10/15
Date

Liesl Centenera
A/g Executive Director, People, Strategy and Services
ACT Health

29/10/15
Date

Sarwan Kumar
Internal Audit & Risk Manager
ACT Health

2/11/15
Date

Matt O'Donnell
Partner
Deloitte

27 October 2015
Date

3 Background

3.1 Identification of relevant compliance sources

From the legislation, regulations, agreements and better practice identified in the Terms of Reference, and from references made within these identified documents, we assessed the following documents as relevant compliance sources by which ACT Health governs the management of allegations of staff misconduct. It is noted that some of the compliance sources (such as legislation and agreements) take precedence over other compliance sources (such as specific ACTPS policies and procedures).

The documents below have been referred to in this assessment as "relevant compliance sources":

Type of document	Document
Commonwealth legislation	*Fair Work Act 2009 (Cth)*
Commonwealth regulations	*Fair Work Regulations 2009 (Cth)*
ACT legislation	*Discrimination Act 1991 (ACT)*
	Human Rights Act 2004 (ACT)
	Public Interest Disclosures Act 2012 (ACT)
	Public Sector Management Act 1994 (ACT)
	Territory Records Act 2002 (ACT)
	Work Health and Safety Act 2011 (ACT)
ACT standards	*Public Sector Management Standards 2006 (ACT)*
Enterprise Agreements	ACTPS Administration and Related Classifications Enterprise Agreement 2013-2017[1]
ACTPS policies and procedures (better practice)	ACT Public Sector Code of Ethics 2010
	ACTPS Code of Conduct 2013
	ACTPS Integrity Policy 2010
	ACTPS Open Door Protocol Guidelines
	ACTPS Preventing Work Bullying Guidelines 2010
	ACTPS Respect, Equity and Diversity Framework 2010

[1] We identified the ACTPS Administration and Related Classifications Enterprise Agreement 2013-2017 as a current and representative Enterprise Agreement, and assessed this Enterprise Agreement for the purpose of our assessment. The other ACT Health Enterprise Agreements identified in the Terms of Reference (ACT Public Service Health Directorate (Health Professionals) Enterprise Agreement 2011-2013; ACT Public Service Medical Practitioners Enterprise Agreement 2011-2013 and ACT Public Service Health Directorate Enterprise Agreement 2011-2013) are no longer current and were not assessed.

Type of document	Document
	Chief Minister and Treasury Guidelines for Independent Reviewers and Appeals Panels 2010
	Chief Minister's Department Respect at Work Policy

3.2 ACT Health framework for managing allegations of staff misconduct

The following documents were identified as comprising ACT Health's framework for managing allegations of staff misconduct, and were assessed to identify ACT Health's adherence to the requirements and better practice disclosed by the identified legislation, regulations, agreements and better practice. This assessment refers to these policies, procedures and guidelines as the "ACT Health framework":

Type of document	Document
Policy	Anti-Discrimination, Harassment and Bullying Policy (February 2011)
	Misconduct and Discipline Policy (August 2013)
	Public Interest Disclosure Policy (Review Date September 2011)
Procedure	Managing Workplace Issues Procedures
Guideline	ACT Health Investigative Process
	Anti-Discrimination, Bullying and Harassment Standard Operating Procedures (February 2011)
Template	Letter to Complainant - Preliminary Assessment Notification
	Letter to Complainant - Investigation Notification
	Letter to Complainant - Progress of Investigation
	Letter to Complainant - Final Outcome
	Letter to Respondent - Preliminary Assessment
	Letter to Respondent - Preliminary Assessment Outcome (No Investigation)
	Letter to Respondent - Investigation Notification
	Letter to Respondent - Progress of Investigation
	Letter to Respondent - Interview
	Letter to Respondent - Investigation Incomplete
	Letter to Respondent - Outcome (Not Proven)
	Letter to Respondent - Outcome (Proven and Proposed Sanction)
	Letter to Respondent - Final Outcome
Register	Sample of ACT Health Caseload Register
	Sample of ACT Health Enquiry Register

4 Detailed findings

The following section details the key findings of the review, including associated recommendations and management responses.

Risk assessment of findings

Findings identified in the review process were allocated risk ratings in accordance with risk rating definitions in ACT Health Integrated Risk Management Guidelines. Further details are provided at Appendix G. The following table provides the level of management action required for each risk rating category:

Rating scale for individual findings	
Extreme Risk	All possible action is taken at Executive level, to avoid and insure against these risks.
High Risk	Generally managers are accountable and responsible personally for ensuring that these risks are managed effectively.
Medium Risk	Accountability and responsibility for effective management of these risks is delegated to line managers at an appropriate level.
Low Risk	These risks are managed in the course of routine procedures, with regular review and reporting through management processes.

4.1 Findings

Compliance requirements for the ACT Health framework to manage staff misconduct and workplace issues are listed in section 3.1. This assessment refers to these as relevant compliance sources and they include the following:

- Legislative requirements from Commonwealth and ACT Government legislation; and
- Requirements from ACT Standards and Enterprise Agreements.

These relevant compliance sources change due to the introduction, amendment, succession or cessation of compliance sources over time. ACT Health is not updating the related policies, procedure and guidelines in a timely manner as these changes occur. This finding is detailed under the following heading:

- Introduction, amendment, succession and cessation of relevant compliance sources.

In addition, these relevant compliance sources govern the management of ACT Health allegations of staff misconduct in the following areas:

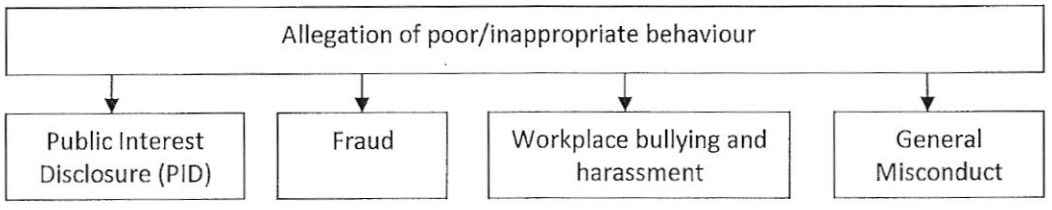
- The level and extent of communication between involved parties;
- Processes around liaison and referrals;
- Processes and procedures for the conduct of investigations; and
- Processes and procedures relating to staff management and disciplinary actions.

Appendices C, D, E and F provide our detailed observations on the ACT Health framework. The appendices are structured to broadly reflect the progression of steps by which ACT Health manages misconduct and workplace issues:

- Management of workplace issues (Appendix C);
- Preliminary investigation (Appendix D);
- Investigation (Appendix E); and
- Reporting and disciplinary action (Appendix F).

These Appendices also assess whether ACT Health's framework is non-compliant or partially compliant with the requirements of relevant compliance sources. Where areas were found to be compliant these have not been included in the Appendices.

Diagram showing ACT Health staff misconduct framework



Misconduct may be involved across four areas: Public Interest Disclosure (PID); fraud; workplace bullying and harassment; and general misconduct. Requirements around misconduct makes up

one element of the process, but each of the four areas have their own additional requirements. Therefore, in this assessment, reference to the ACT Health staff misconduct framework primarily refers to the misconduct requirements. It does not include all the additional specific processes for PIDs or fraud that need to be addressed.

Findings and observations

Introduction, amendment, succession and cessation of relevant compliance sources

Several of ACT Health's relevant policies, procedures and guidelines dealing with misconduct and workplace issues were released between 2011 and 2013, and as such do not reflect the requirements of relevant compliance sources that have been introduced, amended, succeeded or ceased to operate during this time – such as the *Public Interest Disclosures Act 2012 (ACT)* and new Enterprise Agreements for 2013-2017.

The following key findings were identified (please refer to Appendices C, D, E and F for further details):

- The Public Interest Disclosure Policy makes reference to a superseded version of the *Public Interest Disclosure Act 2012 (ACT).* For example, the Public Interest Disclosure Policy states Section 21 of this Act relates to the referral of matters to the Ombudsman (page 6), whereas Section 21 of the *Public Interest Disclosure Act 2012 (ACT)* actually refers to the referral of matters to the chief police officer.
- New Enterprise Agreements have redefined several key terms and processes in the management of misconduct and workplace issues, which are not reflected in the ACT Health framework. For instance, the Misconduct and Discipline Policy's definition of "misconduct" (page 4) reflects five of the six components of the definition of "misconduct" in the ACTPS Administration and Related Classifications Enterprise Agreement 2013-2017 (Clause H6.5), but does not state that "*The employee makes a vexatious or knowingly false allegation against another employee*" is an instance of misconduct.
- The ACT Health framework does not adequately cover the provisions of existing compliance sources. For example, although the Managing Workplace Issues Procedures identifies the "*RED Framework*" in its Reference list (page 10), the operative provisions of the ACTPS Respect, Equity and Diversity framework are not discussed in the ACT Health framework.

Communication with involved parties

The ACT Health framework incorporates a commitment to procedural fairness and effective communication with the complainant, respondent and other parties involved in misconduct and workplace issues (involved parties). However, ACT Health's communication strategies are not fully aligned with the requirements of relevant compliance sources.

Most of these instances involve a general policy concerning communication. However, relevant compliance sources disclose more prescriptive requirements.

The following key findings were identified (please refer to Appendices C and E for further details):

- ACT Health's approach to communication with involved parties contradicts the requirements of relevant compliance sources. For example, the Public Interest Disclosure Policy identifies *"feedback to the informant* [complainant] *is only obligatory where a Progress Report request has been made under section 23 of the Act"* (page 10). This contradicts the requirement that an investigating entity for a public interest disclosure must inform the complainant of the progress of an investigation unless the complaint was made anonymously or the complainant has requested in writing not to be kept informed under Section 23(1) of the *Public Interest Disclosure Act 2012 (ACT).*

- The Anti-Discrimination, Harassment and Bullying Policy states *"Both the staff member raising the complaint (the complainant) and the person/persons against whom the complaint is made (the respondent/s) will receive appropriate information, support and assistance in resolving the grievance"* (page 2). However, the ACTPS Preventing Work Bullying Guidelines 2010 states *"All relevant parties need to be informed of the process, how long it will take and what they can expect to happen during the process and at the end. Provide all parties with clear reasons for the actions that are taken or not taken"* (page 24). While this general statement in the Anti-Discrimination, Harassment and Bullying Policy indicates issues of procedural fairness and communication have been considered, full alignment with the ACTPS Preventing Work Bullying Guidelines 2010 require the inclusion of more detail on the content and timing of communications to involved parties.

Liaison and referrals

Although the ACT Health framework makes reference to several entities relevant to the management and investigation of workplace issues, they do not encompass the full scope of relationships outlined within relevant compliance sources.

The following key findings were identified (please refer to Appendix C for further details):

- The full scope of liaison procedures under the *Public Interest Disclosure Act 2012 (ACT)* (such as the referral of a matter to another public sector entity) is not included in the ACT Health Staff Misconduct framework.

- Although the Managing Workplace Issues Procedures identifies the *"Fraud Management Framework Control Plan & Policy"* in its Reference list (page 10), the ACT Health framework does not separately reference liaison and referral procedures to the Australian Federal Police.

Investigative procedures

The relevant compliance sources, although not overly prescriptive, do identify a number of requirements concerning investigative procedures. Several investigative procedures are not discussed in the ACT Health framework.

The following key finding was identified (please refer to Appendices D and E for further details):

- There are several areas (such as accessing ICT records and planning investigations) where the ACT Health framework does not fully align with relevant compliance sources.

Management of disciplinary actions

There are a number of compliance sources (particularly ACT Health's Enterprise Agreements) that identify the timing, situations, processes and procedures relating to staff management and disciplinary actions that are required to be adhered to. These include the re-assignment, transfer, suspension and termination of employees.

There are instances where the ACT Health framework either does not discuss the provisions of relevant compliance sources or does not align with the full requirements relating to staff management and disciplinary actions.

The following key findings were identified (please refer to Appendices C and F for further details):

- One provision concerning the termination of employees that contradicts the terms of the current Enterprise Agreement. The ACTPS Administration and Related Classifications Enterprise Agreement 2013-2017 identifies *"Notwithstanding the provisions of this section, the employment of an employee may be summarily terminated without notice for serious and wilful misconduct"* (Clause H7.2). In contrast, the Anti-Discrimination, Bullying and Harassment Standard Operating Procedures states *"If the Delegate determines that discrimination, bullying and/or harassment has occurred, the Delegate may immediately terminate the employee's employment, without giving the employee five working days to respond to the allegations"* (page 4). This does not mention that termination without notice only applies to cases of serious and wilful misconduct.
- The ACT Health framework does not discuss several important aspects of the suspension policy under the Enterprise Agreement. The missing aspects include: timeframes for suspension without pay; review of re-assignments; transfers and suspensions; payment for employees that are re-assigned; transferred or suspended or the intersection of disciplinary actions and criminal activity.

Implication

The failure of ACT Health framework to adequately reflect the appropriate requirements of the relevant compliance sources relating to:

- The introduction, amendment, succession and cessation of relevant compliance sources (24 observations– 12 non-compliant, 12 partially compliant);
- Communication with involved parties (seven observations– one non-compliant, six partially compliant);
- Liaison and referrals (seven observations – five non-compliant, two partially compliant);
- Investigative procedures (four observations – four non-compliant) ; and
- Management of disciplinary actions (20 observations – 13 non-compliant, seven partially compliant).

may lead to potential breaches of legislation; increased risk that workplace issues may not be appropriately dealt with leaving ACT Health exposed for not following due process; investigations not being conducted in a consistent manner; and potential breaches of Enterprise Agreements, legislation and other mandated compliance requirements. Appendices C, D, E and F

detail potential areas for improvements for the ACT Health framework based on our observations.

Recommendation 1

ACT Health should update the identified policies, procedures and guidelines to reflect the relevant compliance sources for ACT Health.

Risk Rating

Low

Responsible Officer

Executive Director, People Strategy and Services

Management comments

Partially agree

ACT Health notes the extensive discussions that have taken place to finalise this audit and appreciates the detailed analysis of relevant compliance sources. While recognising the value of linking documents, the recommendation supports a very different approach to the relationship between source compliance documents and best practice policies and guidelines. The position across the ACT Public Sector is that the latter should explain and augment the former, rather than repeat requirements, so that documents are encouraged to be read in conjunction.

ACT Health notes that the audit findings did not find any policy and/or guideline incorrect, but has provided plenty of suggestions aimed at improving their quality and comprehensiveness. With this in mind, the policies and guidelines will be reassessed to consider where references to compliance sources can be usefully added.

Implementation Timeframe

Owing to the time that has elapsed since the audit commenced, a significant number of the framework documents have been reviewed as part of compliance with accreditation requirements. Accordingly, many of the observations refer to out-of-date material. However, a further review of the documentation will be undertaken to consider including relevant references and is expected to be complete in November 2015.

Appendix A Action sheet

Area Audited:	Assessment of ACT Health's management of staff misconduct and workplace issues
Date of Audit:	January 2015

	Audit Recommendation	Management Comment	Responsible Officer	Estimated Completion Date
1	ACT Health should update the identified policies, procedures and guidelines to adequately reflect the appropriate requirements of relevant compliance sources	Partially agreed. ACT Health notes the different approach to the role of policies and guidelines made in this report. Nevertheless, ACT Health will review and amend the current policies and guidelines where appropriate.	Executive Director People Strategy and Services.	November 2015

Appendix B Personnel consulted

The following ACT Health personnel were consulted as part of this audit. We are appreciative of their assistance.

- Judi Childs – Executive Director, People, Strategy and Services
- Liesl Centenera – A/g Executive Director, People Strategy and Services
- Joel Madden – Director of Employment Services, Canberra Hospital and Health Services
- Sean McDonnell – Director of Employment Services, Strategy and Corporate
- Cheryl Condon – Senior Investigator, Employment Services, Strategy and Corporate

Appendix C Management of workplace issues

Observations	Compliance statement[2]	ACT Health documentation where reference to compliance statement was found[3]
Non-compliant		
Observation The Respect, Equity and Diversity framework is not discussed in the ACT Health framework beyond being referenced as a related document in the Managing Workplace Issues Procedures Area for Improvement The requirements of the Respect, Equity and Diversity framework should be embedded in the ACT Health framework	**1a)** At anytime a worker may seek advice from their Agency's RED contact officer (ACTPS Open Door Protocol Guidelines page 2) **1b)** Enquiries to RED contact officers should remain anonymous, to give workers confidence that they can progress issues as they feel comfortable. However, RED contact officers may not be able to guarantee confidentiality if there is a risk to work safety or criminal activity is alleged (ACTPS Preventing Work Bullying Guidelines 2010 page 27) **1c)** Workers should not raise matters that are already under formal investigation or where a process is being undertaken, with executive officers or RED contact officers (ACTPS Open Door Protocol Guidelines page 3) **1d)** In situations where the RED Contact Officer feels uncomfortable about responding to an enquiry or complaint, they should refer the individual to their agency human resources area or their executive sponsor (ACTPS Preventing Work Bullying Guidelines 2010 page 27) **1e)** It is not the role of RED contact officers to resolve work bullying or discrimination issues. Their role is to provide information and guidance to workers who may be the subject of work bullying or discrimination at work (ACTPS Preventing Work Bullying Guidelines 2010 page 27)	RED Framework (Managing Workplace Issues Procedures page 10)
Observation The ACT Health framework does not cover the process for making complaints, and does not include a template for reporting complaints	**2)** The complaint should be in writing with specific allegations including dates, times and names of any witnesses. An agency template should exist for this purpose to make the reporting process easier for the complainant (ACTPS Preventing Work Bullying Guidelines	No reference found

[2] The requirements of the legislation, regulations, agreements and better practice identified as the relevant compliance framework have been edited for length and clarity for ease of reference in some instances. Please refer to the original source for the full compliance statements.

[3] References to the relevant ACT Health documentation have been edited for length and clarity for ease of reference in some instances. Please refer to the original source for the full statements and contextual information.

Observations	Compliance statement	ACT Health documentation where reference to compliance statement was found
Area for Improvement The ACT Health framework should cover the process for making complaints. In addition, a template for reporting complaints should be developed and distributed	2010 page 36-7)	
Observation The ACT Health framework does not cover the requirements concerning executive employees outlined in the *Public Sector Management Standards 2006 (ACT)* Area for Improvement The requirements of the *Public Sector Management Standards 2006 (ACT)* should be embedded in the ACT Health framework	**3a)** The relevant person for an executive employee may, by written notice to the employee, do one or more of the following (*Public Sector Management Standards 2006 (ACT)* s636C(2)): - Suspend the employee from work without pay - Suspend the employee from work with pay - Transfer the employee to other duties **3b)** In taking suspension or transfer actions against an executive employee, the relevant person for an executive employee must follow (*Public Sector Management Standards 2006 (ACT)* s636C(4)): - Misconduct policy made under the *Public Sector Management Standards 2006 (ACT)*, or - Principles of natural justice and procedural fairness	No reference found
Observation The ACT Health framework does not cover the rate of pay for an employee suspended, reassigned or transferred with pay following an allegation of misconduct Area for Improvement The ACT Health framework should cover the rate of pay for an employee suspended, reassigned or transferred with pay following an allegation of misconduct under the Enterprise Agreement	**4)** Whilst suspended with pay an employee will be paid (Enterprise Agreement H8.5): - The employee's ordinary hourly rate of pay and any higher duties allowances that would have been paid to the employee for the period they would otherwise have been on duty - Overtime (but not overtime meal allowance) and shift penalty payments where there is a regular and consistent pattern of extra duty or shift work being performed over the previous six months which would have been expected to continue but for the suspension from duty - Any other allowance or payment (including under an Attraction and Retention Incentive) of a regular or on-going nature that is not conditional on performance of duties (Enterprise Agreement H8.5) This procedure will also apply in circumstances where an employee has been reassigned or transferred with pay to other duties following an allegation of misconduct (Enterprise Agreement H8.3)	No reference found
Observation The ACT Health framework does not cover requirements concerning suspension without pay or the review of reassignments, transfers and suspensions without pay Area for Improvement The ACT Health framework should cover the requirements concerning suspension without	**5a)** Whilst suspended without pay (Enterprise Agreement H8.9): - The suspension will not be for more than thirty calendar days, unless exceptional circumstances apply - The employee may apply to the head of service for permission to seek alternate employment outside the ACTPS for the period of the suspension or until the permission is revoked - In cases of demonstrated hardship, the employee may access accrued long service leave and/or annual leave	No reference found

Observations	Compliance statement	ACT Health documentation where reference to compliance statement was found
pay under the Enterprise Agreement	- The employee may apply to the head of service for the suspension to be with pay on the grounds of demonstrated hardship **5b)** The suspension without pay should be reviewed every thirty calendar days unless the head of service considers that, in the circumstances, a longer period is appropriate (Enterprise Agreement H8.10) This procedure will also apply in circumstances where an employee has been reassigned or transferred with pay to other duties following an allegation of misconduct (Enterprise Agreement H8.3)	
Observation The ACT Health framework does not cover the suspension of an employee where criminal charges are laid against an employee Area for Improvement The ACT Health framework should cover the requirements concerning suspension without pay under the Enterprise Agreement	**6)** Where criminal charges are laid against an employee and the interests of the Directorate or of the ACTPS may be adversely affected, the head of service may suspend the employee (Enterprise Agreement H11.2)	No reference found
Observation The ACT Health framework does not cover the requirement concerning the availability of employees who are suspended to participate in the disciplinary process Area for Improvement The ACT Health framework should cover the requirements concerning the availability of employees who are suspended to participate in the disciplinary process under the Enterprise Agreement	**7)** An employee who is suspended must be available to attend work and participate in the disciplinary process as directed within 48 hours of the direction being given unless they are on authorised leave (Enterprise Agreement H8.7)	No reference found
Observation The ACT Health framework does not cover the repayment of pay and crediting of accrued leave Area for Improvement The ACT Health framework should cover the repayment of pay and crediting of accrued leave under the Enterprise Agreement	**8)** An employee suspended without pay and who is later acquitted of the criminal offence, or found not to have been guilty of the misconduct (Enterprise Agreement 8.11): - Is entitled to be repaid the amount by which the employee's pay was reduced - Is entitled to be credited with any period of long service or annual leave that was take	No reference found
Observation The ACT Health framework does not cover the non-accrual of service	**9)** Where an employee is suspended and later found guilty of a criminal offence (whether or not a conviction is recorded), or is found guilty of misconduct and is dismissed because of the offence or misconduct, a period of suspension does not count as service for any purpose,	No reference found