2012

Legislative Assembly for the Australian Capital Territory

# ACT Mental Health (Treatment and Care) Act Amendment Bill 2012

(First Exposure Draft)

## Draft Explanatory Statement

Circulated by authority of

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**PURPOSE**

The purpose of this explanatory statement is to assist those who are affected by the changes to the Act, and those who administer and make decisions under the Act, to understand and interpret the new provisions.

**BACKGROUND**

The changes to ACT Mental Health (Treatment and Care) Act 1994 proposed by the 2012 Amendment Bill are informed by a review process which has involved wide consultation with the ACT community and stakeholders. A thorough examination of the impact of including consideration of a person's *decision making capacity* when making involuntary orders under mental health law was undertaken during this time. Decision making capacity is currently the most significant focus of change in mental health law internationally.

The review has also involved examination of changes in other jurisdictions in Australia and internationally. The goal of the review was to embody in legislation the changes in approach to mental health service delivery since the previous Act came in to force in 1994, including the increased emphasis on human rights reflected in the ACT Human Rights Act 2004, and the focus on Recovery in mental health care.

In the evolution of mental health legislation, there has been increasing recognition of the rights of people with mental illness. The current revisions to the ACT Mental Health Treatment and Care Act continue this trend. The inclusion of consideration of a person's own decision making capacity when deciding involuntary treatment orders, the legal recognition of Advance Agreements and the identification of a nominated person to advise the treating team of the person's wishes are developments which strengthen the role of mental health consumers in deciding their treatment.

The Recovery approach to service delivery changes the nature of engagement between services and mental health consumers and therefore requires consideration at a principle level to guide decisions taken under the Act. The recovery view is that the consumer is not defined by their illness. There is potential for mental illness and recovery to be experienced as a journey of healing, transformation and hope, and services work with consumers towards a goal of maximum social participation. The recovery approach holds that consumers take the lead in achieving their recovery, participating in decisions about their treatment care and support as much as possible.

A number of provisions have been made to increase oversight of treatment and care of forensic mental health and forensic disability clients. These provisions bring together and clarify measures which were previously expressed in several different acts, and therefore were challenging to apply.

The provisions aim for the best balance between protecting the safety of the community and protecting the rights of the individual in treatment.

**MAJOR CHANGES TO THE ACT**

***Include decision making capacity as a criterion when the ACAT is considering applications for mental health orders.***

Including decision making capacity (referred to in this document as capacity) as a criterion for deciding certain involuntary treatment orders, aligns mental health law with legislation in broader health and supports the right of people with mental illness to equality before the law. Under guardianship law, which applies in the broader health environment, a person may make their own decisions if they are assessed as having capacity to do so. Previously, involuntary care in mental health law has been decided principally on the basis of the person's assessed risk to themselves and/or to the community.

Nationally and internationally, mental health law is moving towards consideration of a person's decision making capacity as a basis for deciding whether the person requires involuntary treatment. Research suggests that risk is often difficult to assess reliably, and that under risk criteria alone (contrary to human rights requirements) a significant number of people who have capacity to make their own decisions are placed on involuntary treatment orders, while a number of people who are treated voluntarily in fact lack the capacity to give informed consent.

Decision making capacity comprises the ability to: understand the available options; understand the consequences of choosing from those options; and clearly communicate a decision. It may also, and in the case of this legislation does, include the stability of those abilities over time. This is because the capacity of people with some mental health conditions can change quickly. For example, a person who has bipolar affective disorder may in some cases change from having good judgement about the consequences of an action to very poor judgement within hours or days. As another example, people with some personality disorders or post traumatic stress disorder (PTSD) may find that their good judgement is highly vulnerable to being overcome by impulsivity because of 'trigger' events at some stages of their condition. The person should not be regarded as having decision making capacity for mental health treatment if it is likely that their capacity will be highly volatile, taking into account the period for which treatment is indicated and the limits on the ability of the health system to respond in a short timeframe.

However, anyone, regardless of their mental state, is liable to make errors in decision making, and a person cannot be held to lack capacity simply because they have made a decision that the assessor considers unwise, or with which they disagree.

Research evidence shows that decision making capacity can be reliably assessed, and a variety of instruments are available for assessment.[1] A person may have capacity, have impaired or partial capacity, or lack capacity to make decisions. If the person is assessed as having capacity, the legislation requires that they should make their own decision (in consultation with others as they wish) unless there is a significant overriding risk. If a person's decision making capacity is impaired, then they should be supported to understand the implications of the decision so that they can then make their own decision or contribute to the decision to the best of their ability. Substitute decision making through guardianship or a mental health order should only be considered if the person is assessed as not having capacity even when appropriately supported, or where functioning support is not available. Support for decision making depends on the existence of a trust relationship with someone who can help the person understand the implications.

Risk criteria are retained in the revised Act, so that if a person is assessed as having capacity, but there is still considered to be a clear overriding risk of harm to self or others, the person may be placed on an involuntary order. It is considered that such circumstances would be rare, but at the time of drafting the new law, no jurisdiction in Australia or internationally has moved to 'pure' capacity based legislation and it was not considered reasonable for the ACT, as a small jurisdiction, to bear the risk of being the first to make this change. The criteria for involuntary orders will be reviewed after 3 years.

***Define mental illness and mental dysfunction as separate entities, and create distinct parts in the Act providing for involuntary treatment care and support for mental illness; mental dysfunction; and forensic mental health***

In clinical practice, the term mental dysfunction is used for conditions such as intellectual disability, acquired brain injury, cognitive disorders such as dementia, developmental disorders such as autism, behavioural disorders including Attention Deficit Hyperactivity Disorder (ADHD), and substance use disorders including alcohol induced brain disorders. It is not used to describe mental illness.

The ACT is unique in Australia in providing for people with mental dysfunction in the same Act as that for mental illness. Other jurisdictions provide for mental dysfunction under disability legislation. In the review process for the Act, sectors of the community argued that providing for the three areas (mental illness, mental dysfunction and forensic mental health) helps to perpetuate the confusion of mental illness with developmental delay, and an exaggerated perception of the link between mental illness and violence. This advocacy tended to support the idea of three separate Acts. However it is also recognised that the framework of mental health legislation, including its strong and increasing

[1] Mental Capacity in Psychiatric Patients: A Systematic Review. David Okai, Gareth Owen, Hugh McGuire, Swaran Singh, Rachael Churchill and Matthew Hotopf. BJP 2007, 191: 291-297

human rights focus, is protective for people with mental dysfunction and those with forensic mental health problems. As a way of resolving these conflicting concerns, stakeholders agreed on creating separate parts in the Act for provisions particularly relating to each area.

There is also seen to be advantage in having mental illness and mental dysfunction dealt with under the same Act, with the same guiding set of principles, because when treatment orders are being considered it may not be clear which condition (and at times it may be both) applies.

**FORMAL CLAUSES**

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| **Amendment Bill Clause** | **1 - 4** |
| **ACT Mental Health Act Section** | **n/a** |

**Name**

Names the Act to amend the Mental Health (Treatment and Care) Act 1994: The Mental Health (Treatment and Care) Amendment Act 2012

**Commencement**

This clause provides that the amendment Act will commence on a day fixed by the Minister. A maximum of six months from the initial commencement date may be allowed for some provisions in order to develop supporting structures and processes.

**Legislation amended**

The legislation amended is the Mental Health (Treatment and Care) Act 1994, with consequential amendments required to other ACT legislation.

**Long title**

Identifies the Act as having the purpose to, "provide for the treatment, care, support, rehabilitation and protection of people with a mental dysfunction or mental illness and the promotion of mental health and wellbeing, and for other purposes".

**MAIN CLAUSES**

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| **Amendment Bill Clause** | **5 - Part 1 Heading** |
| **ACT Mental Health Act Section** | **Chapter 1 Preliminary** |

**Chapters**

The Amendment Bill introduces Chapters as the highest level of heading to the Act to organise the subject matter more clearly. Within Chapters are Parts and within Parts are Divisions.

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| **Amendment Bill Clause** | **7 – part 2** |
| **ACT Mental Health Act Section** | **Chapters 2 – 3, Sections 7, 8, 9-9R** |

**Sections 7 and 8 Objectives and Principles**

Section 7, Objectives and Section 8 Principles, set the framework for the amended Act and guide decisions made under the Act. Statutory office holders refer to them when making those decisions. Principles stand at a higher level than objectives. Objectives relate more directly to the practical outcomes of decisions under the Act.

The new objectives and principles serve to underline and promote legislative intent in safeguarding and promoting the rights of consumers under the Act. They will guide interpretation of the Act where needed. They are amended to align with:

a. the *ACT Human Rights Act, 2004,* which has been enacted since the last Mental Health Act was passed.
b. a recovery approach to service delivery, adopted as policy by mental health services in the ACT. In recent years, there has been a national and international move toward a recovery approach in service delivery. This approach significantly changes the relationship between services and its consumers and has therefore been reflected in the guiding principles of the Act. The recovery approach recognizes that the outcomes of mental health treatment, care and support are affected by the expectations of everyone involved. It includes the following concepts:

    i. consumers are not defined by their illness;
    ii. mental illness or dysfunction can be experienced as a journey of healing, transformation and hope.
    iii. consumers take the lead in their recovery, actively participating in decisions around their treatment as far as possible.
    iv. Compliance with treatment is not taken as consent.
    v. assisted decision making should prevail over substituted decision making. Advance Agreements for consumers also complement this principle.

**Section 9 Decision Making Principles**

The decision making principles are taken from the Code of Practice for the UK Mental Capacity Act (2005). The issues around consideration of decision making capacity in mental health are set out under 'Major Changes to the Act' above.

**Sections 9A Meaning of Mental Dysfunction and 9B Meaning of Mental Illness**

These definitions have been amended and will now aid the separation of the Act into provisions for mental illness and mental dysfunction, as set out under 'Major Changes to the Act' above.

**Chapter 3 Assessments (Sections 9C to 9R)**

Prior to the current amendments, assessment orders were only made by the ACAT in circumstances where the ACAT had before it an application for a Mental Health Order. Any person including the subject of the application, their family or friends, or other concerned person, could apply.

The amendments allow anyone to apply for an assessment order, and restrict the role of applying for mental health treatment orders to the Chief Psychiatrist or Care Coordinator or a relevant person approved by them. These changes allow anyone with a concern to ask for assessment, while the application for order will follow from a professional opinion (previously the ACAT have had to request this assessment and opinion to inform their decision if the application for order did not include a professional assessment). The advantages of the change are:

a) There is a more logical flow to the application process
b) Family or friends will now apply for an assessment, giving them 'arms length' from the application for order, and helping to preserve their relationship with the person
c) In the case of a self application, it is more logical for a person to apply for an assessment order than a treatment order. A self application for treatment brings into question the persons eligibility for a mental health order (a treatment order) under the criteria, whereas this question can be resolved through the assessment process.
d) As part of the changes, the ACAT is able to consider an assessment separately from an order, eliminating unnecessary continuation of order hearings where the assessment does not indicate the need for an order.

**Section 9H (a) - Evidence Criterion for an Assessment Order**

Provides for the ACAT to order an assessment if they are satisfied on the basis of the information in the application that a person *appears to have* a mental illness or dysfunction, rather than *is* (on the basis of the application) mentally ill or dysfunctional. The language in the previous version of the Act appeared to prejudge the situation. This change makes the legislation reflect the balance of probability that the ACAT must consider when deciding whether to make an assessment order. It is

not reasonable to ask the ACAT to be convinced whether the person has mental illness or not, when the outcome of the assessment is not yet known.

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| **Amendment Bill Clause** | **10 – sections 10 & 11** |
| **ACT Mental Health Act Section** | **10 - Applications for mental health orders** |

Former Section 10 (self-application for mental health order) and Section 11 (under which any person may apply for an order) have been replaced with a new Section 10 (The Chief Psychiatrist, Care Coordinator or a relevant person approved by them, may apply for an order) because of the expanded role of Assessment Orders in the new provisions. See notes under Assessment Orders above.

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| **Amendment Bill Clause** | **11 – referrals to ACAT** |
| **ACT Mental Health Act Section** | **13(3) Note** |

This note clarifies that if a person's assessment under an Assessment Order indicates the need for a mental health order, they can then be considered for a mental health order without the need for a separate application for an order.

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| **Amendment Bill Clause** | **12 -13 - Assessments** |
| **ACT Mental Health Act Section** | **Old Division 4.2, and 4.3 -4.7** |

Old Division 4.2 (Assessments) is omitted as it has been replaced with the new provisions for assessment under Sections 9C to 9R. Old Divisions 4.3 – 4.7 are renumbered as Divisions 4.2 - 4.6

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| **Amendment Bill Clause** | **15** |
| **ACT Mental Health Act Section** | **Section 23(2)** |

Requires the ACAT to take into account the recency of the assessment on which an application for order is based. The intention of this provision is to enable the ACAT to ensure that the assessment is recent enough to reflect the person's current mental state.

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| **Amendment Bill Clause** | **16** |
| **ACT Mental Health Act Section** | **25(3)** |

The intention of this clause is to ensure that before making an order, the ACAT has written evidence before it that treatment is available. Availability of treatment is a criterion for making orders.

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| **Amendment Bill Clause** | **17, 22 & 24** |
| **ACT Mental Health Act Section** | **Sections 26(A), 28(2)(d) and 29(3)** |

These sections now include references to the need for ACAT to establish whether the person has decision making capacity, in accordance with the introduction of decision making capacity as a criterion for orders in this amendment bill. See more detailed discussion above, under Major Changes to the Act on p3.

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| **Amendment Bill Clause** | **26** |
| **ACT Mental Health Act Section** | **35 (2A and 2B)** |

**Section 35 (2A)**

Prevents a person being subject to seclusion for any period longer than 4 hours without medical examination. The intention of this provision is to ensure that a person is not subjected to extended seclusion without medical review, and to help ensure that seclusion is limited to the minimum time necessary.

**Section 35(2B)**

This section clarifies the power of the chief psychiatrist to use the minimum force necessary to give medication under an involuntary order where a person is refusing treatment.

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| **Amendment Bill Clause** | **27** |
| **ACT Mental Health Act Section** | **35(3)** |

The objectives of the Act have been revised, and a new section of principles included (see Sections 7 and 8) in the context of the ACT Human Rights Act, which has come into effect since the previous iteration of the Mental Health Act. By referring to the new principles and objectives, this change to Section 35 draws attention to the broader range of rights (including the maintenance of the person's freedom, dignity and self respect) that the Chief Psychiatrist must now consider when directing involuntary treatment.

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| **Amendment Bill Clause** | **28** |
| **ACT Mental Health Act Section** | **35(4)** |

This amendment adds involuntary giving of medication to the matters (the others being restraint and seclusion) for which the Chief Psychiatrist must:

- enter the reason into the persons record;

- advise the Public Advocate and ACAT in writing within 24 hours, and
- maintain a record.

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| **Amendment Bill Clause** | **32** |
| **ACT Mental Health Act Section** | **36D (3) (b) (iv)** |

Adds a Health Attorney (where the Health Attorney is currently involved in decisions regarding the person's care) to the list of people the Care Coordinator must consult before determining treatment, care and support arrangements for the person under a community care order.

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| **Amendment Bill Clause** | **36** |
| **ACT Mental Health Act Section** | **36G (2A)** |

Restricts seclusion under a community care order, in the same way provided for under a psychiatric treatment order by Section 35 (2A) above.

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| **Amendment Bill Clause** | **37** |
| **ACT Mental Health Act Section** | **36G (4)** |

This mirrors provisions discussed above at clause 27 in relation to Section 35(3).

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| **Amendment Bill Clause** | **43** |
| **ACT Mental Health Act Section** | **36K (5) and (6)** |

Ambulance paramedics are being provided with power to apprehend a person under the Mental Health Act. This change has the support of mental health consumer representatives, as it is expected to significantly reduce the number of occasions where the police are involved in bringing people to a facility for assessment. Police may still need to be involved if the person is resisting.

At the 18 April 2008 Australian Health Ministers Conference (AHMC) meeting, Ministers endorsed the 'National Safe Transport Principles'. This document lays out the broad principles to be considered when developing the protocols and procedures for the safe transport of mental health consumers.

Under current arrangements, police are often called to transport a person under Emergency Detention to a hospital. It is commonly argued that police involvement is necessary, due to perceptions of high risk to safety for those involved. However, nationally there is a movement that sees ambulance services as first responders, with mental health services, for mental health consumers requiring health assistance in accessing hospital services. The *National Emergency*

*Mental Health Care Principles 2008,* state that police involvement in transport should be a last resort, and only where this is consistent with the police role in ensuring public and consumer safety. The movement to preference a first response by ambulance rather than police for emergency transport to hospital of mental health consumers reflects the expressed preference of Mental Health consumers and carers and recognises that the issue is primarily a health rather than police issue.

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| **Amendment Bill Clause** | **54** |
| **ACT Mental Health Act Section** | **40** |

Previously this section required that a person brought to an approved mental health facility for examination be examined within four hours, but did not set out whether detention under Section 37 (an Emergency Action) lapsed if the examination had not been carried out in this time, or what action should then be taken.

This amendment provides where the person is not examined as required within four hours the person in charge of the facility must notify the Chief Psychiatrist who will ensure that the assessment is undertaken within a period no greater than 2 hours after the Chief Psychiatrist is notified. The intention of these provisions is to ensure that the person is examined without undue delay, and that they are held for the minimum amount of time necessary given that they have been detained and not yet examined, which is a considerable restriction of their rights.

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| **Amendment Bill Clause** | **55** |
| **ACT Mental Health Act Section** | **41 (2)** |

**Authorisation of Involuntary Detention**

Emergency detention is an involuntary order, or two successive orders, made when a person is acutely unwell, requiring treatment, lacking decision making capacity and at risk of harm to themselves or others. It is a period provided for assessment and emergency treatment of a person before either; an application for a longer term treatment order, or the person becomes a voluntary patient, or is discharged. A three day detention can be ordered by the doctor who makes the initial assessment. During the three days an additional 11 day (previously seven day) detention order can be authorised on written application to the Tribunal. Either order can be rescinded at any time if no longer needed. Both orders are appealable to the Tribunal.

**Human Rights Implications**

Emergency Orders involve the highest level of restriction of rights, because they are made without the Tribunal hearing required for treatment orders. With the extension of the second order by four

days the period of emergency detention in the ACT remains among the shortest in Australia (for example 28 days in Victoria). This is done in the interest of providing the person with the opportunity to make their case as soon as possible, and minimising the time in which this level of restriction of a person's rights is applied. Against an early hearing is the need for the person to have time to recover sufficiently from their acute phase of illness, in order to be able to argue their case in the ACAT hearing process held to decide a longer term order (if one is applied for). The period of emergency detention also allows the person time to consider engaging in voluntary treatment (which a person will often decide to do after they have begun treatment) and for the treating team to consider whether a longer-term treatment order is needed. The period of emergency detention allows the person time to prepare and consult with legal representation before a hearing.

It is expected that the extension of the emergency detention period by four days will reduce the number of initial longer term treatment orders. The experience of a tribunal hearing and of being placed on a longer term involuntary order is usually distressing for the person, and there is evidence that some longer term orders are shown to be unnecessary after a short period of time. Given the balance of human rights considerations, consumer representatives agreed to the extension, provided that a review was conducted after 18 months to test the effectiveness of the change. This has been provided for in Section 41 (4).

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| **Amendment Bill Clause** | **60-69. Part 5A – interstate arrangements** |
| **ACT Mental Health Act Section** | **Chapter 15** |

Interstate application of mental health laws is relocated at Chapter 15 and renumbered accordingly.

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| **Amendment Bill Clause** | **70** |
| **ACT Mental Health Act Section** | **NEW FORENSIC SECTION**<br>**Chapter 6 (Forensic), 7 (Corrections) sections 48A – 48Z7L** |

**Chapter 6 Forensic Mental Health Orders**

**Purpose of the Chapter**

Chapter six inserts a new part into the Act that applies to people with a mental illness or dysfunction who have come into contact with the criminal justice system. Previously civil mental health laws were used to provide involuntary mental health treatment to adult and young people in this category. The amendments ensure that the law adequately caters for forensic mental health orders and limits detriment to patient care and community safety.

The purpose of the new provisions is to:

i. provide for the care, treatment and support of persons subject to criminal proceedings who are living with a mental illness or mental dysfunction;
ii. ensure the safety of members of the community from the risk of serious harm; and
iii. promote the least intrusive treatment and care of those people.

The provisions establish a new suite of 'forensic orders' based on existing civil orders for people with a mental illness but which allow the ACT Civil and Administrative Appeals Tribunal (the ACAT) to make either a therapeutic facility based order or a community based order.
The forensic order scheme aims to provide appropriate oversight of and safeguards for, forensic patients. The scheme will also facilitate appropriate service responses for forensic mental health clients living in the community with support and supervision by relevant health, disability and/or justice services.

**Human Rights Considerations**

Chapter 6 engages a number of rights in the ACT's Human Rights Act 2004 (the HR Act).
The Bill engages, and places limitations on, the following HR Act rights:

- Section 8 – Non-discrimination and equality before the law
- Section 10 – Protection from torture and cruel, inhuman or degrading treatment
- Section 11 – Protection of the family and children
- Section 12 – Privacy and reputation
- Section 13 – Freedom of movement
- Section 15 – Peaceful Assembly and freedom of association
- Section 18 – Right to liberty and security of person
- Section 19 - Humane treatment when deprived of liberty
- Section 21 – Fair trial

The Bill engages, and supports, the following HR Act rights:

- Section 10 – Protection from torture or cruel, inhuman or degrading treatment
- Section 19 – Humane treatment when deprived of liberty

Mental Health laws generally require balancing a range of competing rights and interests. On one hand, human rights law seeks to protect a person's right to liberty and personal decision making. On the other hand the community has a legitimate expectation that it will be protected from a serious risk of harm and that people will be protected from harm resulting from any condition that impairs their capacity to action their own best interests[2].

[2] P32 Australian mental health tribunals

The responsibility of governments to undertake measures to protect their citizens has been discussed in European human rights jurisprudence. This responsibility has been described as the 'doctrine of positive obligations' which encompasses the notion that governments not only have the responsibility to ensure that human rights are free from violation, but that governments are required to provide for the full enjoyment of rights.[3] This notion has been interpreted as requiring states to put in place legislative and administrative frameworks designed to deter conduct that infringes human rights and to undertake operational measures to protect an individual who is at risk of suffering treatment that would infringe their rights.[4]

The new objects and principles of the Act contained in chapter 2 of the Amendment Bill apply to the forensic mental health provisions. The principles and objectives set a framework and provide a rationale for decisions made under the Act. They serve to remind people taking action under the Act of the natural rights and freedoms of people with mental illness and mental dysfunction. In ordering a mental health forensic order ACAT will be mindful to and guided by the objects and principles.

How does the Amendment Bill limit people's rights?

Limits on the fundamental rights protected by the HR Act are permissible only if the limits are authorised by a Territory law and are reasonable and demonstrably justifiable in a democratic society.

Forensic mental health orders impose limitations on the rights of people subject to a forensic mental health order. An order may contain one or more of the following restrictions on a person, depending on the type of order and can be imposed without the consent of the person:

- Take a person to an approved mental health facility or community care facility for care or treatment;
- Undergo involuntary treatment such as psychiatric treatment (other than electroconvulsive therapy or psychiatric surgery), counseling, training or a therapeutic or rehabilitation program;
- Limit communication between the person and other people;
- That the person must live at a certain place;
- That a person must not approach a stated person or stated place or undertake stated activities; and
- That the person may be given medication in the course of treatment.

[3] Colvin, M & Cooper, J, 2009 *'Human Rights in the Investigation and Prosecution of Crime'* Oxford University Press, p. 424-425
[4] Ibid, p.425.

In addition to a forensic psychiatric treatment order the ACAT may make an order to detain a person at a mental health facility. Similarly in addition to a community care treatment order the ACAT may make an order to detain a person at a community care facility.

The Act recognises that a person with a mental illness has the right to liberty and autonomy. Proportionate restrictions are placed on these rights to protect the community and the person from harm. The restrictions contained in the forensic mental health provisions are the least restrictive in terms of achieving the purposes of the provisions. There are also mechanisms contained in Chapter six to further ensure that the limitations on rights are the least restrictive and only applied in appropriate circumstances.

How are these restrictions on human rights limited?

The Act ensures that there are safeguards in place to make sure limitations on rights are proportionate.

When considering an application for a forensic mental health order, the primary focus of the ACAT is to provide for the treatment and care of a mentally ill or mentally dysfunctional person who has come to the attention of the justice system and to protect the community from harm. The question of whether a person's behaviour constitutes a risk to community safety is therefore a question to be determined by an analysis of available medical and other advice.

Before making a forensic order the ACAT must:

- consider an appropriate assessment of the person
- hold an inquiry into the matter
- consult with the person (if the person is a child, the person with parental responsibility for the child), the persons legal guardian, the person most likely to be responsible for the persons treatment proposed to be ordered
- consider whether treatment should take place in a facility or in the community

Furthermore there are a range of factors that the ACAT must take into account in making the order which includes the persons consent or decision making capacity; the views of each person appearing at the proceedings; that restrictions placed on the person should be the minimum necessary; and that the persons rights should be appropriately protected.

Forensic orders can only be applied to someone who meets the criteria set out in chapter 6 section 48J for a psychiatric treatment order or section 48Q for a forensic community care order. Firstly the person must have involvement with the criminal justice system. This may occur in a number of ways, for example where:

- a person is charged and the charge is subsequently dismissed and the person is referred to the ACAT (section 334 (2) (a) *Crimes Act 1900,*
- a person is remanded by a court in relation an ongoing criminal charge;
- a person's case is still being considered by the court and has been found either temporarily or permanently unfit to plead;
- a person is found not guilty by reason of mental impairment and the person is referred to the ACAT for the making of mental health orders; and
- a person is serving a custodial or community based sentence.

The person must have a mental illness and most significantly, the person must pose a substantial risk to their own health or safety or is doing or is likely to do serious harm to others.

Furthermore the ACAT be satisfied that psychiatric treatment or the community care is likely to reduce the deterioration of the person's mental health or the endangerment to the community.

If a person meets this criteria than the ACAT may make a forensic mental health order including restrictions mentioned previously.

Under both a psychiatric treatment order and a community care order there are systems in place for people who provide care and treatment to the person to inform the ACAT that an order is no longer appropriate. Such a notice requires the ACAT to review the order within 72 hours after being notified.

Furthermore Chapter six provides review mechanisms in relation to forensic orders. This provides further protection to ensure that the limitations on a person's rights are proportionate and justified. Under the review provisions ACAT may review an order on application or on its own initiative.

**Sharing information (Part 6.2)**

People with mental illness involved in the justice system often move between the corrections system and the health system with responsibility being shared by both.

Failure to release consumer personal information to interested parties involved in the ongoing care of a consumer, has been implicated in poor outcomes for consumers. A 2004 Report from the HREOC, the Mental Health Council of Australia and the Brain and Mind Research Institute, noted that the complexity of and misunderstanding about privacy laws and policies, has hindered communication between consumers, carers and clinicians and has led to obstructions in the provision of treatment and support to consumers.

Appropriate sharing of relevant health information allows for continuity of care and seamlessness of service provision. This in turn helps to prevent consumers "falling through the cracks" when multiple services are variously concerned in their care.

The provisions allow for sharing of information that is reasonably necessary for the performance of a function under the Act. What is reasonably necessary may be considered in terms of being necessary for the safe and effective care of the person.

The provision is set out at the level of principle. The provision for development of an information sharing protocol enables the specifics of what information needs to be shared, to be negotiated between services. This enables the protection of the person's privacy to be maximised in a way that is difficult to provide for in legislation.

Information sharing principles have been incorporated into analogous legislation in other Australia jurisdictions, such as NSW. The Mental Health Legislation Amendment (Forensic Provisions) Bill (2008) (NSW), introduced a range of amendments regarding the sharing of information by agencies providing services to forensic patients. Queensland and South Australia have also enacted analogous information sharing laws for forensic patients.

**Part 6.3 Affected people**

**Purpose of this part**

These provisions relate to victims (as defined in the ACT Victims of Crime Act 1994) of offending behaviour perpetrated by forensic mental health clients. These people are referred to in the Bill as "affected people" to underline the therapeutic rather than punitive context of the ACT Mental Health (Treatment and Care) Act (1994) as well as the affected person's right to dignity in the face of the harmful behaviour to which they have been subjected.

Part 6.3 acknowledges the rights of affected people to have their views and concerns adequately addressed in processes for forensic patients who committed harmful acts. At present provisions that specifically relate to affected people are notably absent from the Mental Health Act. The inclusion of specific provisions for forensic patients within the Act requires that the rights of affected people be addressed in the legislation.

There is limited existing scope for the views and concerns of affected persons to be considered in the context of an inquiry by the ACAT for a Mental Health order. Under the new provisions an affected person will be able to inform the Civil and Administrative Tribunal (ACAT) about concerns they hold regarding the person subject to a forensic mental health order. The provisions give the

ACAT an opportunity to consider additional information about the harmful behaviour and its consequences for the affected person over time.

The provisions provide for an affected person to represent their rights and interests before the ACAT in the form of a statement where a decision of the ACAT regarding a mental health forensic consumer is likely to affect these people.

The proposed provisions aim to ensure that affected person information is available for use by the ACAT and to allow the Victim of Crime Commissioner to advocate in the ACAT on behalf of an affected person. The provisions also aim to give affected people limited information relating to a relevant forensic patient, in particular where the movements of the person subject to an order may affect the rights and interests of an affected person.

**Human rights considerations**

Growing international recognition of the rights and needs of victims of crime was recognised in the 1985 United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power.

The ACT introduced legislation implementing the UN victim's declaration through the Victims of Crime Act 1994. The Victims of Crime Act includes governing principles for the treatment of victims in the administration of justice. However these principles do not apply under the Victims of Crime Act when a person is referred to the ACAT because of a mental illness. Amending the Mental Health Act will ensure that the interests of people affected by the harmful acts of forensic mental health consumers are represented.

The provisions also seek to balance the rights of the affected person with the rights of the person coming before the ACAT. In relation to the person before the ACAT, in regards to a forensic order application, the provisions engage and limit the right to privacy and reputation under section 12 of the HR Act. The right to privacy and reputation has been described as protecting a broad range of personal interests that include physical or bodily integrity, personal identity and lifestyle (including sexuality and sexual orientation), reputation, family life, the home and home environment and correspondence (which encompasses all forms of communication)[5].

General comment 16 from the Office of the High Commissioner for Human Rights describes this right as the right of every person to be protected against arbitrary or unlawful interference with their privacy, family, home or correspondence as well as unlawful attacks against a person's honour

[5] Lester QC., Pannick QC (General editors), 2005, *Human Rights Law and Practice'*, Second edition,LexisNexis UK, p.261.

and reputation. The comment notes that the term 'unlawful' means that no interference can take place except in cases envisaged by the law[6].

The term 'arbitrary interference' is described by General Comment 16 as intending to guarantee that even interference provided by law should be in accordance with the provisions, aims and objectives of the UN International Covenant on Civil and Political Rights (ICCPR) and should be reasonable in the particular circumstances[7].

Therefore, it is reasonable to suggest that a person's right to privacy can be interfered with, provided the interference is both lawful (allowed for by the law) and not arbitrary (reasonable in the circumstances).

Privacy is a basic human right recognised by the Mental Health Act and it is important that provisions that limit a person's privacy properly balance the mental health consumer's right to privacy and the affected person's rights.

How does the Act limit Human Rights?

Part 6.3 creates "an affected person register". This register is maintained by the Director- General responsible for the administration of the ACT Civil and Administrative Tribunal Act 2008. An affected person, or someone acting on their behalf, can request to be placed on the register.

As soon as practicable after placing the affected person on to the register the director-general must provide the affected person, orally or in writing about the rights of affected people to information about the offender.

If a forensic mental health order has been made in relation to the offender the director general may disclose information about the person to a registered affected person in relation to the offence if satisfied that disclosure is appropriate.

What restrictions are there to the limitation?

Only an affected person can be placed on the register. An affected person refers to someone harmed by an offence, committed or alleged to have been committed by a person, whom a forensic mental health order applies or may apply. This includes a person who suffered harm from witnessing an offence.

If the affected person is a child under 15 years old, the information may be given to their parent or legal guardian.

[6]Office of the United Nations High Commissioner for Human Rights, Human Rights Committee, 1988 'General Comment No.16: the right to respect of privacy, family, home and correspondence, and protection of honour and reputation', para.3.
Available:(http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/23378a8724595410c12563ed004aeecd?Opendocument)

[7] Ibid, para 4.

The Director General may disclose information about the adult to a registered affected person in relation to the offence if satisfied the disclosure is necessary for the affected person's safety and wellbeing. Examples of disclosure include and are not limited to:

- whether the defendant is detained as an inpatient or out in the community;
- whether a defendant has been granted leave from a mental health facility;
- an application for a forensic mental health order in relation to the person;
- if the person absconds from a mental health facility or community care facility;
- if the person is transferred to or from another jurisdiction; or
- if the person is released from a mental health facility or community care facility.

The director-general must not disclose identifying information for a child offender unless the offence was a personal violence offence and the director-general believes that the affected person, or a family member of the affected person, may come into contact with the child.

Literature on the needs and rights of victims strongly indicates that the early provision of support and accurate information is fundamental to the prevention of re-traumatisation and the promotion of recovery. Therefore the limitation on the right to privacy is reasonable to protect the rights of affected people. The intention of these provisions is to provide affected people with information that is linked to their experience as an affected person. A balance is struck between the legitimate needs of affected people for information and the interests of people subject to a forensic mental health order.

**Chapter 7 Correctional patients**

**Purpose of this part**

There is a high prevalence of mental health disorders among prisoners in Australia compared to the general community. This means that addressing mental health needs of detainees at the Alexander Maconochie Centre requires an integrated response from health and justice agencies.

Provisions for the transfer of detainees to a mental health facility already exists in the *Corrections Management Act 2007* but there is no legislative provision that differentiates detainees receiving mental health treatment under civil mental health detention provisions in the MHA from detainees receiving voluntary mental health treatment who are detained under another Act.

New chapter 7 creates a 'corrections mental health classification' for detainees who require transfer from a correctional centre to a mental health facility. Such a classification would apply to a person with a mental illness who requires inpatient mental health treatment and who consents to such treatment.

Chapter 7 will allow for systems to be put in place to, supported by legislation to:

- monitor and control the transfer of voluntary patients between corrections and mental health facilities;
- put in place appropriate approval mechanisms for such transfers;
- monitor the timing of and any delays in the transfer of such patients; and
- allow for the appropriate transfer of such patients to other jurisdictions under interstate correctional patient legislative provisions.

**Human rights considerations**

The United Nations *Standard Minimum Rules for the Treatment of Prisoners* provide the following protection for people with mental illness in correctional facilities:

> 1. People with a mental illness, who are not convicted, shall not be detained in prisons and arrangements shall be made to remove them to mental institutions as soon as possible.
> 2. Prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialised institutions under medical management.
> 3. During their stay in a prison, such prisoners shall be placed under the special supervision of a medical officer.
> 4. The medical or psychiatric service of the penal institutions shall provide for the psychiatric treatment of all other prisoners who are in need of such treatment.

The Corrections Management Act requires that detainees should receive health care equivalent to the community standard. This is premised on the view that the fact of detention should not be an impediment to the delivery of health care consistent with Australian norms. Furthermore, the Corrections Management Act provides an entitlement of health care and disease and injury prevention to a degree equal to that provided for the rest of the Territory community.

Furthermore the ACT Human Rights Act protects the rights of detainees. Chapter 7 limits and supports the following rights:

- Section 10 – Protection from torture and cruel, inhuman or degrading treatment etc
- Section 18 – Right to liberty and security of the person
- Section 19 – Humane treatment when deprived of liberty

**<u>Section 10 – protection from torture and cruel, inhuman or degrading treatment</u>**

Section 10 of the Human Rights Act provides the protection from torture and cruel, inhuman or degrading treatment. Torture has been defined as "any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted by or at the instigation of a public official on a person for such purposes as obtaining from him or a third person information or confession, punishing him for an act he has committed or is suspected of having committed, or intimidating him

or other persons[8]." The infliction, or in many cases, the toleration of suffering that does not constitute torture - for example, because it is less severe or because it is not intentionally inflicted - constitutes cruel, inhuman, or degrading treatment[9].

Neglecting to provide needed treatment to alleviate mental suffering may violate this section, as may deliberately with holding such treatment. The prohibition should be interpreted to extend the widest possible protection against abuses, whether physical or mental[10].

If a detainee's mental health deteriorates and they endure serious psychological suffering because they have not been provided the mental health treatment required their right to be free of cruel or inhuman treatment may have been violated[11].

The amendments provide that if the Chief Psychiatrist is satisfied that a detainee has a mental dysfunction or mental illness they may request that detainee be transferred to a mental health facility or community care facility under the direction of the Director General responsible for the administration of the Corrections Management Act 2007. The amendments also provide the ACAT with review functions in relation to transfer directions.

**Section 18 – Right to liberty and security of the person**

Section 18 of the HR Act provides the right to liberty of person; in particular, no one may be arbitrarily arrested or detained. A detainee has their right to liberty limited whilst they serve their prison sentence. This limitation on their right to liberty is reasonable as it is in accordance with procedures established by law. A prisoner's right to liberty should not be limited once their prison sentence has been served as it would be an unreasonable limitation on the right under section 18. The amendments ensure that:

- if a detainee's sentence of imprisonment ends;
- the person is released on parole;
- the person is otherwise released from the detention on the order of a court;
- the relevant charge against the person is dismissed; or
- the director of prosecutions notifies the ACAT or a court that the relevant person will not proceed.

**[8] Declaration on the Protection of All Persons from Being Subjected to Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment Adopted by General Assembly resolution 3452 (XXX) of 9 December 1975, Article 1.**

[9] Human Rights Watch, *Ill-Equipped: US Prisons and Offenders with Mental Illness*, October 2003 http://www.hrw.org/en/reports/2003/10/21/ill-equipped-0

[10] Ibid.
[11] Ibid.

The director-general must-

- at the person's request continue the detention, treatment or care in the mental health facility; or
- make any decision that the director-general may make in relation to the person under this Act; or
- release the person from mental health facility.

These provisions ensure that no one is arbitrarily detained under the new amendments. In effect, where a person is no longer subject to a 'corrections transfer', they must either be released or allowed to remain at the facility voluntarily. Further under section 48ZJ(2)(b) the Director General may make any other decision they feel is appropriate in relation to the person. In limited circumstances the Director General may be of the view that it is appropriate that a mental health order should be sought from the ACAT. In this situation the Director General would consult with the Chief Psychiatrist who would make an application to ACAT. These provisions ensure the continuity of care to individuals that have a mental illness have access to treatment once their sentence ends. This issue is further explored under section 19'humane treatment when deprived of liberty.

These provisions ensure the continuity of care to individuals that have a mental illness have access to treatment once their sentence ends. This issue is further explored under section 19'humane treatment when deprived of liberty.

Furthermore a detainee on a transfer direction may apply at anytime to the ACAT to be transferred to a correctional centre. This ensures that a detainee remains in a mental health facility or community care centre only as a voluntary patient.

**Section 19 – Humane treatment when deprived of liberty**

Section 19 of the HR Act provides that anyone deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person. The United Nations Human Rights Committee (the HR Committee) has stated that compliance with article 10 of the International Covenant on Civil and Political Rights (ICCPR) (akin to section 19 of the HR Act) requires prison management to ensure mental health treatment for prisoners with mental disabilities as well as humane conditions of confinement".[12]

A human rights approach to mental health treatment for prisoners further recognises the importance of continuity of care to ensure that individuals have access to treatment once released. The Standard Minimum Rules for the Treatment of Prisoners notes that correctional facilities should work with the appropriate agencies to determine what after-care services are necessary and can be

[12] Human Rights Committee, General Comment 21, article 10 (Forty-fourth session, 1992), replaces general comment 9 concerning humane treatment of persons deprived of liberty, U.N. Doc. HRI/GEN/1/Rev.1 at 33 (1994). http://www.unhchr.ch/tbs/doc.nsf/0/3327552b9511fb98c12563ed004cbe59?Open...

arranged so that individuals will have necessary treatment, care, and support when they return to the community[13].

The amendments ensure that there are procedures in place for detainees with a mental illness to receive the required treatment. This engages and supports the humane treatment of detainees when deprived of their liberty. The scope of the right to humane treatment of people deprived of liberty has been outlined under article 10 of the ICCPR and considered further by the HR Committee in General Comment No 21/1992. Treating all people deprived of their liberty with humanity and with respect for their dignity is a fundamental and universally applicable rule. This rule must be applied without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.[14]

The obligation on the State to ensure that a person is detained in conditions which are compatible with respect for their human dignity was affirmed in the cases of *Eastman v Chief Executive of the Department of Justice and Community Safety*[15] and *Enea v Italy*[16]. In the Eastman case, Justice Refshauge expanded on the subject of the State's obligation to ensure detainees are to be treated humanely stating that under section 19 of the HR Act "the State must ensure that a person is detained in conditions which are compatible with respect for his human dignity", free from "distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention, and that given the practical demands of imprisonment, his health and well-being are adequately secured".[17]

The amendments support the humane treatment of detainees whilst incarcerated in a detention centre. The new provisions streamline the transfer of correctional patients to a mental health facility or community care facility. This ensures that detainees have access to appropriate mental health care that may not be available within the prison.

**Schedule 1 part 1.2 *Crimes Act 1900 – Limiting Term***

Part 1.2 of schedule 1 of the Bill makes substantive amendments to the *Crimes Act 1900* part 13 'Unfitness to plead and mental impairment'. The amendments are in relation to the way the Supreme Court determines a 'limiting term' following a special hearing.

[13]Standard Minimum Rules for the Treatment of Prisoners (SMR), adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of May 13, 1977, http://www2.ohchr.org/english/law/treatmentprisoners.htm,art. 81.
[14] Alexander, T, Bagaric, M & Faris, P , 2011 '*Australian Human Rights Law*', CCH Australia, page 292.
[15] [2010] ACTSC 4
[16] [2009] ECHR 74912/01
[17] *Eastman v Chief Executive of the Department of Justice and Community Safety* [2010] ACTSC 4

A special hearing is held when a person is found by a court to be unfit to plead by reason of mental impairment and is unlikely to become fit within 12 months. As far as possible special hearings are conducted as if they were ordinary criminal proceedings.

Unlike a normal trial the outcome of a special hearing is a verdict of either 'acquitted' or 'not acquitted'. A non-acquittal entitles the court to order that the accused be detained and referred to the jurisdiction of the Tribunal. Before doing so, the court must specify a 'limiting term'. The effect of the limiting term is that the Tribunal cannot require a person to remain in custody for longer than the limiting term set by the Court.

The limiting term aims to ensure that an offender is not unfairly disadvantaged in terms of sentence length compared to a notionally "well" offender who has committed the same offence.

In *Steurer v the Queen* [2009] ACTSC 150, Justice Hillary Penfold commented critically on the requirement for the setting a limiting term in the Crimes Act. Justice Penfold describes the considerations for determining the limiting term, applicable to mentally fit accused persons regarding sentencing, to those whose sentencing is affected by mental impairment considerations, as inappropriate.

The matters raised by Justice Penfold with respect to the setting of a limiting term in *Steurer* go to the tension between the different focus of the therapeutic and community safety goals of the special hearing on the one hand and the criminal justice goals of normal criminal proceedings on the other. Without removing the requirement for the setting of a limiting term, it is not possible to wholly resolve these tensions.

The proposed amendments in Part 1.2 adopt amendments made to the NSW *Mental Health (Forensic Provisions) Act 1990* in 2008 to address matters raised in *Steurer*. These changes will allow the Court to:

- impose any other penalty or make any other order it might have made on conviction of the person, such as setting no term as would apply in a community based sentence; and
- take into account the periods, if any, of the person's custody or detention before, during and after the special hearing (being periods related to the offence).

The amendments are designed to better reflect the considerations that should inform the Court in the exercise of setting a limiting term.

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| **Amendment Bill Clause** | **72** |
| **ACT Mental Health Act Section** | **Chapter 8, Parts 8.2 (nominated people) and 8.3 (advance agreements), Sections 53A – 53L** |

**Section 53A Nominated Person**

Provides a role for a *nominated person*, who is someone chosen by the subject person, when the person has capacity, as someone who can be consulted regarding the preferences for treatment, care and support when the person does not have capacity. The nomination is agreed by a representative of the persons treating team and recorded as part of the person's Advanced Agreement (see below) or elsewhere in their record. A nominated person is specified as someone to be consulted when making various decisions made under the Act.

Without this provision, the treating team or other decision makers may not know the person's preference for who should be consulted. The nominated person provision therefore increases the subject person's opportunity to have input to treatment decisions.

**Section 53B – 53L Advance Agreements (AAs)**

Legal recognition of AAs is introduced by these amendments. AAs in various forms are increasingly gaining recognition in mental health. They have been established in ACT mental health services after a development process of several years involving consumer representatives and other stakeholders, but they have not had legal recognition. They parallel advance directives in broader health, in enabling the person when they have capacity to plan their treatment care and support. In the mental health legislation of some jurisdictions the person may simply record their preferences with an appropriate witness, and this record then becomes a document to be taken into account when planning treatment, but has no legal power. However, in the ACT the AA is an agreement made in negotiation with the person's treating team. It has therefore been given more legal status in these provisions. The provisions enhance the person's right to equality before the law and equal protection of the law, by ensuring that as far as possible the person's choices made when they have decision making capacity, are followed if they lack capacity. The only instance where the AA may be varied without the person's consent is where the treating team feels that treatment in the AA is inappropriate to the person's current condition. In this circumstance, the treating team may apply for a mental health order to override those provisions of the AA considered inappropriate.

An AA is made when the consumer is deemed to have decision making capacity in relation to their future care. It is a written, signed agreement negotiated between the consumer and the treating team, and may involve a carer. It sets out the consumer's preferences for treatment, care and support. It details the way the person wants to be treated and not treated around their mental

health, any other preferences the person may wish to express regarding treatment and the involvement or otherwise of family members or others in decisions around their care.

Because most mental illnesses are episodic, AAs have two main advantages: Firstly, a person who recognises that they are likely to resist or be reluctant to have treatment when they are unwell because of impaired decision making associated with their illness, has the opportunity to agree to future treatment when they are well and do have capacity. In the process of developing the legal framework for AAs, a number of consumer representatives expressed the wish that an AA would remain legally binding on them if they attempted to withdraw it when unwell and lacking capacity. However, the balance of opinion was that the person should always have the right to withdraw consent, whether they have capacity or not. This reflects the situation applying to advance directives and consent to treatment generally, in the broader health environment. Options for involuntary treatment may then be pursued if the circumstances warrant.

Secondly, the person's input to treatment planning through the AA means that treatment, care and support provided when they do not have capacity is likely to suit them (as an example, this can help people to avoid medications with side effects they cannot tolerate). The development of an AA enables the person to use the knowledge they have gained from previous treatment, and incorporate this into a future treatment plan through discussion and negotiation with the treating team.

Other statements of consumer intention are not recognised as AAs for the purpose of the Act, if not agreed to and signed by the treating team and the consumer, however they can be considered in planning treatment. AAs must be reviewed each 12 months.

The provisions include:

- That the AA should be reviewed each 12 months, to ensure that it remains current (Section 53E), but that if the AA lapses, it continues to be a document to be taken into account in planning treatment (53J).
- That the person may end their AA by advising, orally or in writing, any person involved in their treatment (53G). This reflects the provisions for consent to treatment in broader health.
- That a mental health order or forensic mental health order prevails over an AA only to the extent that the order is inconsistent with the AA(53K). It is unstated in the Act but legally correct that if an order ends during the time in which an AA is in force, the provisions over which the order has prevailed return to force for the rest of the duration of the AA.
- That if a Guardian or Power of Attorney is appointed, their decisions prevail to the extent that they are inconsistent with the AA.

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| **Amendment Bill Clause** | **73 – 83, Part 7 Electroconvulsive Therapy and Psychiatric surgery** |
| **ACT Mental Health Act Section** | **Chapter 9** |

**Electroconvulsive Therapy and Young People**

The use of electro-convulsive therapy (ECT) to treat mental illness in young people is very rare.

The new restrictions on ECT for young people align ACT legislation with recent and impending legislation in other jurisdictions, based on the lack of evidence to support ECT under 12 years. Consultations in the ACT and other jurisdictions have concluded that ECT needs to be retained as a legal treatment for young people from 12 years of age up to 18, for the very rare occasions where it is the only effective and potentially life-saving treatment.

In order to give ECT to a young person (at least 12 years old and not yet 18), the treatment must be recommended by two psychiatrists, at least one of whom is a Child and Adolescent specialist, and ordered by a full sitting of ACAT.

The objective of the restrictions is to achieve a balance between clinically indicated need and concerns regarding potential harm from ECT. While there is currently no evidence that the developing brains of young people are at additional risk due to ECT, concern remains that this may be the case. Against this there are very rare occasions, such as extreme mania, where ECT is considered life saving and the only acceptable option because the amount of medication required to manage the condition would be well above safe levels.

ECT is used for treatment of severe depressive, manic or psychotic symptoms, or after all other treatment options have failed, or when the situation is thought to be life-threatening.

ECT is a safe and effective treatment for severe depression, with 70–90 per cent of severely depressed people treated with ECT showing a positive response; and as an alternative treatment for bipolar disorder, especially in people with chronic, recurrent illness or in those who cannot tolerate medications.

The main side effect of ECT is short term memory loss or confusion, which is experienced by a minority of patients. This has to be viewed in the context of the side effect profile which applies to all medications used in psychiatry, and the fact that ECT is potentially life - saving when a person is at risk of exhausting themselves with severe mania, or making highly dangerous decisions, or is suicidal with severe depression. Some patients with recurrent depression in fact express a preference for ECT over medication.

The purpose of the procedure set out for authorisation of ECT for young people is to ensure that if the person is to receive treatment, then there is sufficient review of the decision to ensure that the balance of risks has been carefully considered.

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| **Amendment Bill Clause** | **82** |
| **ACT Mental Health Act Section** | **65(ba)** |

This amendment requires that the new criterion of decision making capacity be considered when the Supreme Court is considering an order for psychiatric surgery and the person has not given informed consent or refused to consent.

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| **Amendment Bill Clause** | **90** |
| **ACT Mental Health Act Section** | **77 - 79** |

These provisions bring together in one place for convenient reference, the occasions when the ACAT may consider matters with a presidential member sitting alone, and when there must be a full sitting.

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| **Amendment Bill Clause** | **105 - 107** |
| **ACT Mental Health Act Section** | **121(1A) - 121A** |

**Official Visitors**

Provides for the appointment of a Principal Official Visitor (POV) and sets out the POV role. This has become a requirement due to the increase in the number of official visitors and an expansion of their role.

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| **Amendment Bill Clause** | **111** |
| **ACT Mental Health Act Section** | **Part 12.4** |

**Coordination of Activity**

This recommendation provides for the Chief Minister to appoint a Director General to coordinate, where mental health activity is indicated across directorates and across sectors. Examples include mental health promotion and prevention, and psychosocial actions such as housing and social support which are increasingly recognised as important to recovery and psychological wellbeing.

The field of mental health promotion and prevention recognises the need for prioritisation and coordination of a wide range of activities which enhance mental wellbeing and

resilience, and which help reduce the incidence and impact of mental health problems. The utility of mental health promotion and prevention approaches to mental illness and dysfunction has been increasingly recognised. The current Act does not provide for the government role in coordinating activity in this area. While mental health promotion is integral to broader health promotion, it is an area still in development, and still often a missing key element in health promotion activity. For these reasons, specific recognition of mental health promotion is indicated. The recognition of the role helps to locate clinical treatment in a spectrum of activity that supports better mental health in the population.

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| **Amendment Bill Clause** | **116** |
| **ACT Mental Health Act Section** | **Chapter 14, Sections 139 – 139C** |

**Mental Health Advisory Council**

The Minister currently receives advice from a Mental Health Advisory Council. The Council was set up following a commitment made by ACT Government in 2008 to the electorate to establish, in legislation, a Ministerial Council on Mental Health to ensure consumers of mental health services, carers and the non-government sector are able to provide continuous advice and direction to Government on mental health policy and services. The Council is a mechanism of direct advice from the community to Government. This Section provides a legal framework for the Council's operation.

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| **Amendment Bill Clause** | **Schedule 1 – Legislation Amended** |

**Consequential Amendments**

(These are amendments to other legislation resulting from the changes to the Mental Health (Treatment and Care) Act.)

**Children and Young People's Act 2008**

Has been amended to reflect the revised definitions of mental illness and mental dysfunction in the Mental Health (Treatment and Care) Act

**Corrections Management Act 2007 – new section 54A**

Corrections patients under the mental health act are people who are detained by the justice system, who are voluntarily receiving mental health treatment. This provision ensures the Chief Psychiatrist will be advised if a corrections patient's detention status changes, so that the person can be informed and a decision made regarding further treatment.

**Crimes Act 1900**

The changes made to the Crimes Act revise the framework for setting a *limiting term* (see explanation under Crimes Act, Limiting Term, page 23 above).

**Crimes (Child Sex Offenders) Regulation 2005**

This is a technical amendment that will substitute a new section at 12 (1)(d)(ii) of the *Crimes (Child Sex Offenders) Regulation 2005*. The *Crimes (Child Sex Offenders) Regulation 2005* supports the *Crimes (Child Sex Offender) Act 2005* by providing regulations in relation to the establishment and maintenance of the child sex offenders register, reporting obligations for registered offenders and the exchange and use of information about registered offenders on the child sex offender register. The substitution will ensure that the amendments to the *Mental Health (Treatment and Care) Act 1994* are reflected in the obligations under the *Crimes (Child Sex Offenders) Regulation 2005*. This amendment does not change or impose further obligations on registered offenders who are released from detention under the *Mental Health (Treatment and Care) Act 1994,* it merely clarifies the obligation on the ACAT to provide information about their obligations under the *Crimes (Child Sex Offenders) Act 2005.*

Section 12 of the *Crimes (Child Sex Offenders) Regulation 2005* lists the prescribed entities that must give a registered offender a reporting obligations notice. This is linked to the requirement at section 104 (1) of the *Crimes (Child Sex Offender) Act 2005* which requires prescribed entities to give a registrable offender a notice that states their reporting obligations under the *Crimes (Child Sex Offenders) Act 2005* and the consequences that may arise if the registered offender does not take all reasonable steps to comply with their obligations. This substitution will ensure that the ACAT provides the registrable offender with a reporting obligations notice when they are released from detention under the *Mental Health (Treatment and Care) Act 1994*, chapter 4 (Mental health orders), chapter 5 (Emergency detention) or part 6,1 (Forensic mental health orders).

**Crimes (Sentence Administration) Act 2005**

This is a similar provision to that under the Corrections Management Act set out above.

**Guardianship and Management of Property Act 1991, and Powers of Attorney Act 2006**

Where a person is assessed as not having decision making capacity but is willing to accept treatment, it is not seen as appropriate to make an involuntary treatment order. However the person cannot legally consent to treatment because of lack of capacity. For this circumstance these

Acts have been modified to allow a guardian or power of attorney to consent to treatment. (The situation where a person without capacity refuses or resists treatment is provided for under the Mental Health Act.)

Further provisions ensure that the consent is for the minimum necessary time, ending if the person regains capacity. If the person continues to lack capacity, is no longer willing to accept treatment, and the continuation of treatment is considered necessary, an order under the Mental Health Act can be considered.

**Victims of Crime Act 1994**

These provisions reflect the changes to the Mental Health Act to allow affected people to represent their interests as set out in the Forensic section under Affected People, page 16 above.