Explanatory Statement

Mental Health (Treatment and Care) Amendment Bill 2014

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1. Introduction

The *Mental Health (Treatment and Care) Amendment Bill 2014* ('the Bill') proposes amendments to the *Mental Health (Treatment and Care) Act 1994* ('the Act'). That Act is the legislation that primarily provides for the statutory options, entitlements, and protections of people who use ACT mental health services. It provides for involuntary treatment of mental illness where needed, but aims to ensure that where possible people make their own treatment decisions, or participate in decisions to the extent that they can. The Act also imposes certain obligations on mental health service providers and provides for certain offences.

Since the Act came into effect, there have been many advances in research and community expectations about what constitutes fair and effective supports of people's mental health. Consequently, in 2006, the ACT government commenced a public review of the Act, which concluded in 2013. The Bill is an outcome of that review.

2. Some important notes on language

When reading the Explanatory Statement, please note:

First, while the explanatory statement refers to case law and legislation to ensure the intent of the Bill's clauses is clear, particularly with respect to the rights of people with mental illness/es and/or disorder/s and certain person's obligations to them, plain English materials will be made available in accessible formats to people who are delivering and receiving mental health services and the general public, in the ACT.

Second, use of different verbs – such as oblige, compel, declare and dictate – in this Explanatory Statement to describe mandatory provisions of the Bill is not intended to denote that one obligation is less or more onerous than the other.

Similarly, the Explanatory Statement uses different verbs – such as allow and permit to explain when the Bill gives a certain person the *option* of doing a certain action, rather than a direction to do it. The use of these different verbs is not intended to endow a person with two different levels of permission to do an activity.

Third, the Explanatory Statement employs the phrase 'mental illness/es

and/or disorder/s'. These terms are defined in the Act. It is recognized that individuals may sometimes have multiple mental illnesses or disorders or both mental illness/es and disorder/s.

Fourth, wherever possible, the phrase '*person/people* with mental illness/es and/or disorders', is deployed, rather than the more system-centric terms 'consumer' or 'patient'.

This is to help recognize that:

- people come to treatment, care and support services as individuals who have a variety of needs;
- the services a person receives can only be safe and of a high quality, if they are appropriately shaped by the person's relevant attributes;
- the Bill's provisions are intended to be consistent with the concept of 'recovery', and
- the Bill employs language that is broadly consistent with the language in the *Human Rights Act 2004* and the International Covenant on Civil and Political Rights.

Finally, the separate clauses of the Bill frequently introduce multiple sections as amendments to the Act – for example clause 11 refers to proposed new sections 5-36ZQ and clause 43 to sections 48S – 48ZZU. As a shorthand this Explanatory Statement refers to the Bill and the amendments with expressions such as 'Clause 11's subsection 26(1) (c) or 'Clause 43's subsection 48Y (1) (d).'

3. What major changes are provided for by the Bill?

Some of the clauses that amount to the most significant changes provided for by the Bill are conveniently addressed together as *3.1 Clauses grounded in the 'recovery' concept* and *3.2 Clauses grounded in certain research and the right to health*. They are clustered in this way to help clarify the ideas that underpin them.

3.1 Clauses grounded in 'recovery' concept

All of the Bill's clauses are informed by the concept of 'recovery', as it is used in contemporary mental health contexts. However, some clauses are markedly so. These clauses include those that:

- alter the Objects of the Act;
- establish new Principles that apply to the Act, and
- create new provisions regarding decision-making capacity.

The concept of 'recovery' emerged from what is sometimes referred to as the 'mental health consumer movement', which began in the Western world in the 1970s and 1980s. Since then, the 'recovery' concept has been deployed and refined by people living with mental illness/es, and their advocates, across the world.

Over the last decade and a half, the concept has appreciably influenced what people expect of their mental health services in most economically developed societies.[1] For example, in the ACT it is expressed in, among other things, the ACT Health Directorate's:

- *Paths of Healing: A Guide to Mental Health Recovery* (2011),[2] a public document on people's different paths to recovery from mental illness/es through their chosen aspirations, services, and communities, and
- *Mental Health Recovery in the ACT* (2007),[3] a public document on the philosophy and practices of ACT mental health services.

It is also evident that the concept informed the drafting of Australia's *Fourth national mental health plan: an agenda for collaborative government action in mental health 2009-2014* (2009)[4], *National*

[1] Anthony, W.A. (2007) *Toward a vision of recovery: for mental health and psychiatric* rehabilitation services, Boston University Press, Boston; Slade, M. (2009) 100 ways to support recovery: a guide for mental health professionals, Rethink Recovery Series, Vol. 1; United States Department of Health and Human Services (2011) National consensus statement on mental health recovery, Substance Abuse and Mental Health Services Administration Center for Mental Health Services, Rockville, United States <http://hospitals.unm.edu/bh/psr/consensus.shtml>, accessed 30 September 2013.

[2] <http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1368621732&sid=>, accessed 30 September 2013.

[3] <http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1896383755&sid=>, accessed 30 September 2013.

[4] Commonwealth of Australia (2009) The fourth national mental health plan: an agenda for collaborative government action in mental health 2009–2014, Commonwealth of Australia, Canberra.

standards for mental health services 2010 (2010),[5] and *National framework for recovery-oriented mental health services* (2013)[6].

Publications such as those listed above, and the relevant research literature, define 'recovery'-oriented services in various ways.[7]

The Review generally conceived of recovery-oriented services as those that enable people to self-determine what constitutes a satisfying life for them, even though they may have ongoing symptoms of mental illness/es and/or disorder/s.[8]

It also set out to arrive at reforms that would help ACT mental health services become recovery-oriented ones. This is apparent, for example, in those Bill provisions that steer services towards partnering with each person to base their treatment, care and support on their choices, strengths and goals.

3.1.1 Objects and principles expressly referring to 'recovery'

Several of the Bill provisions explicitly refer to the concept of 'recovery'. These are clause 11's new:

- subsection 5(a), which provides that a new Object of the Act is to 'promote the recovery of people with a mental disorder or mental illness';
- subsection 6(c), which provides that a Principle that applies to the Act is that the person with a mental illness or disorder has a 'right to determine the person's own recovery';
- subsection 6(j)(iv), which states that another Principle is that services 'should promote a person's capacity to determine the person's recovery from mental disorder or mental illness'; and

[5] Department of Health and Ageing (2010) National standards for mental health services, Australian Government, Canberra.

[6] Australian Health Ministers' Advisory Council (2013) *National framework for recovery-oriented mental health services*, endorsed by the Australian Health Ministers' Advisory Council on 12 July 2013 and formally launched by the Council Chair at the Mental Health Services Conference on 21 August 2013.

[7] Davidson, L. (2008) *Recovery: concepts and application*, Recovery Devon Group, United Kingdom.

[8] Shepherd, G., Boardman, J., Slade, M. (2008) *Making recovery a reality*, Sainsbury Centre for Mental Health, London, United Kingdom.

- subsection 6(j)(v), which lays down that another Principle is to 'seek to…promote the person's recovery'.

While none of the other new Objects and Principles expressly refer to 'recovery', they have been influenced by the concept's emphasis on the person being treated in a way that is respectful of their particular needs and attributes.

3.1.2 Change of 'mental dysfunction' to 'mental disorder'

The Bill provides for replacing all instances of 'mental dysfunction' in the Act with 'mental disorder'. As noted in the Explanatory Statement to the Second Exposure Draft of the Bill, the consultation process found that 'mental disorder' was overwhelmingly regarded as 'the preferable term to overcome stigma'.[9]

3.1.3 Decision-making capacity provisions

Many of the Bill's provisions answer the recovery movement's call to support people with mental illness/es and/or disorders to make their own decisions and move away from imposing on them the decisions of substitute decision-makers.

The Bill defines the term 'decision-making capacity' at clause 11's new section 7.

3.1.3.1 'Objects of the Act' and 'Principles applying to the Act'

The Bill newly rests the interpretation of the *Mental Health (Treatment and Care) Act 1994* on the decision-making capacity of people with mental illness/es and/or disorder/s. At clause 11:

- subsection 5(b) makes it an Object of the Act to 'promote the capacity of people with a mental disorder or mental illness to determine, and participate in, their assessment and treatment, care or support, taking into account their rights in relation to mental health under territory law';
- section 6 mandates that the Principles 'must be taken into account' in

[9] ACT Government (2013) Review of the Mental Health (Treatment and Care) Act 1994 - Second Exposure Draft: Proposed changes and explanation, p.14 <http://timetotalk.act.gov.au/storage/Proposed%20changes%20with%20explanation.doc>, accessed 12 July 2013.

the exercise of any function under the Act;

- subsection 6(g) declares as one of the Act's Principles that it is a 'right' of a person with a mental illness and/or disorder 'to be given timely information to…maximise the person's contribution to decision-making about the person's assessment and treatment, care or support';
- subsection 6(i), another of the Act's Principles, holds that it is also a 'right' of such a person 'to be assumed to have decision-making capacity, unless it is established that the person has no decision-making capacity'; and
- subsection 6(j)(iv) states that another Principle of the Act is that services should 'promote a person's capacity to determine the person's recovery from mental disorder or mental illness'.

3.1.3.2 Dedicated 'decision-making capacity principles'

Clause 11's new section 8 is entitled 'Principles of decision-making capacity'. It enumerates the principles that 'must be taken into account' in considering a person's decision-making capacity under the Act.

One of these principles is provided by subsection 8(2). It states that a person's decision-making capacity 'must always be taken into account in deciding treatment, care or support, unless this Act expressly provides otherwise'. Through this subsection, the section 8 'decision-making capacity principles' reinforce how section 6 provides for decision-making capacity, at the subsections 6(g), 6(h) and 6(j)(iv), which 'must be taken into account' in the exercise of any function under the Act.

Similarly, the subsection 8(1)(b) requirement that a person be assumed to have decision-making capacity unless they have no decision-making capacity buttresses subsection 6(i) which states that a person has a right for their decision-making capacity to be assumed in this way.

Further, the section 7 definition of 'decision-making capacity' is clarified by clause 11's new:

- subsection 8(1)(e)(i), prohibiting a person from being regarded as having no decision-making capacity simply because they make an unwise decision;
- subsection 8(1)(e)(ii), forbidding a person from being considered to

have no decision-making capacity only because they have no decision-making capacity under other legislation, and

- subsection 8(1)(f), precluding a person from being deemed to have decision-making capacity merely because they comply with certain treatment, care and support.

According to clause 11's new subsection 8(1)(c), certain assistance must be given to a person as a consequence of their not having decision-making capacity. It requires that a person without decision-making capacity 'always be supported to make decisions about the person's treatment, care or support to the best of the person's ability' and this obligation is bolstered by:

- Clause 11's new subsection 8(1)(d), which forbids a person being treated as if they do not have decision-making capacity 'unless all practicable steps to assist them have been taken' including, but not limited to, providing information in a way that the person is likely to understand and supporting them to communicate in whatever way is appropriate for them and to use existing support networks, appropriate communication aids and independent advocacy services;
- Clause 11's new subsection 8(1)(g), which dictates that 'a person who moves between having and not having decision-making capacity must be given, if reasonably practicable, the opportunity to consider matters requiring a decision at a time when the person has decision-making capacity'; and
- provisions on advance agreements and consent directions, and on nominated persons, which enable people to make known, when they have the decision-making capacity to do so, what medications, procedures and other things they wish included and excluded from their treatment, care and support.

3.1.3.3 Nominated persons, advance agreements, and advance consent directions

Clause 11's new Parts 3.2 and 3.3 ensure that, except in some limited circumstances, what a person does and does not wish to receive, and what they do and do not consent to, in the event that they need treatment, care and support, will be known and heeded by health

professionals, even if the person is unable to advocate for themselves. To see what the narrow exceptions to this rule are, please see the descriptions of clause 11's subsections 28(4) and 28(5) in this section.

The Part 3.2 provisions empower a person with decision-making capacity to nominate an adult who accepts having the role of helping to ensure the person's interests are respected, if and when the person needs treatment, care or support. Other provisions throughout the Bill require that the nominated person is consulted and given certain information about the person at certain times.

Part 3.3 provides for advance agreements and advance consent directions.

An advance agreement and/or an advance consent direction may be entered into between a person with decision-making capacity and their treating team. The Bill provides for the person to include in their agreement:

- their preferences in relation to practical assistance they may need if they are unable to undertake tasks when they may be receiving treatment , such who will care of their property, and
- any information they consider relevant to their treatment care or support, other than information more properly included in an advance consent direction.

An advance consent direction may only be made by an adult with decision-making capacity who has consulted with their treating team about options for their treatment care and support. The person with decision making capacity may make an advance consent direction setting out their consent or refusal of consent to treatment care or support in the future should they lose decision making capacity. The person may also set out the people who may be, and the people who may not be, given information on the treatment, care and support the person requires for a mental illness or disorder

It is intended both advance agreements and advance consent directions be discussed and agreed by the person and their treating team. This is important because of this new legislative basis for both documents and the obligations on mental health professionals in respect of them.

The treating team is required to nominate one of their number to be their representative who undertakes the obligations for the treating team under section 25. Obligations on all members of the treating team are clearly set out in this part. Mental health professionals must:

- take reasonable steps to ascertain whether a person has an advance agreement or consent direction before treating them;
- where reasonably practicable, treat a person without decision-making capacity in accordance with the preferences expressed in their advance agreement, if they have one but not apprehend, detain, restrain or use force to give effect to their agreement, and
- not give a person without capacity a particular medication or procedure, if that person's advance consent direction indicates that the person does not consent to that medication or procedure.

Advance consent directions are intended to provide the necessary authority to treat a person with the medications or procedures to which the person has provided advance consent as long as the person is compliant with the treatment at the time it is to be given. If a treating team proposes to treat a person according to their advance consent direction but the person resists the treatment then the treating team may apply to the ACAT for an order to do so. That is, the ACAT can order that the treating team may go ahead with treating the person in accordance with their advance consent direction. This order is not an order to treat the person in alternative or additional ways in and of itself.

Substitute decision makers also have a role in this sphere. If a health professional believes on reasonable grounds it is unsafe or inappropriate to treat a person without decision-making capacity in accordance with their advance consent direction, the professional may seek the lawful consent of the person's guardian or health attorney under the *Guardianship and Management of Property Act 1991* (Guardianship Act) or the person's attorney under the *Powers of Attorney Act 2006* (*Powers of Attorney Act*) to provide alternative treatment to them. However, the lawfulness of the consent given is dependent on the compliance of the person. If the person resists the alternative treatment then the mental health professional must apply to the ACAT for an order to provide the alternative treatment that is not in accordance with the person's advance consent direction.

Further, the Bill obliges the ACT Civil and Administrative Tribunal (ACAT) to take account of advance agreements and consent directions when considering the making of mental health orders at Clause 11's subsection 36(1)(c) and Clause 43's subsection 48Y(1)(d)

The Bill also provides at clause 11's section 30 and section 31 for how advance agreements and consent directions may or must be regarded by guardians appointed under the *Guardianship Act* and enduring powers of attorney under the *Powers of Attorney Act 2006*. There are important limitations on the powers of a substitute decision maker where the person has expressed their wishes and/or provided or refused consent to particular medications or treatments through advance agreements and advance consent directions.

Guardians and enduring powers of attorney appointees with the authority to give consent for treatment, care or support for a person under the *Mental Health (Treatment and Care) Act 1994* must take into account the person's advance agreement and advance consent direction if the person has made either instrument. This obligation is similar to the obligations both already have under their respective Acts. However, the Guardian or enduring power of consent appointee are not required to give consent to any treatment care or support that the person has provided their own consent to in their advance consent direction. As described above, the guardian may consent to alternative treatment if the person is compliant but first the mental health professional must hold a reasonable belief that the treatment the person has consented to is unsafe and must record their reasons for that belief, before they can propose the alternative treatment to the Guardian for their consent.

3.1.3.4 Decision-making capacity and the ACT Civil and Administrative Tribunal

The Bill makes some new requirements of the ACAT when making psychiatric treatment orders or community care orders that turn on a person's 'decision-making capacity', as defined by new section 7.

The new requirements are at:

- clause 11's new subsection 36T(1)(b), which obliges the ACAT to take into account, in making a mental health order, 'whether the person consents, refuses to consent or has the decision-making capacity to

consent, to a proposed course of treatment, care or support';

- clause 11's new subsections 36V(2) and 36ZD(2), which state that the ACAT can only make a psychiatric treatment order about a person if, among other things, the person has a mental illness and either has *no* decision-making capacity for giving consent to receiving the treatment, care or support and *refuses to receive it* or *has the decision-making capacity to consent, but refuses to consent*;
- clause 11's new subsections 36V(2)(d) and 36ZD(2)(d), which adds that where a person has the decision-making capacity to consent to the treatment, care or support, but refuses to give the consent, the ACAT can only make them the subject of a psychiatric treatment order, if the ACAT is satisfied that their mental or physical deterioration or the harm to them or someone else, likely to result from their illness, is so serious that it outweighs the person's right to refuse to consent;
- clause 11's new subsections 36W(2)(b) and 36ZE(3)(b), which compel the ACAT to include, in a community care order, a statement about how the person who is the subject of the order meets the subsections 36V(2) and 36ZD(2) criteria respectively, which, as is stated above, include certain matters regarding 'decision-making capacity', and

3.1.3.5 Decision-making capacity and the ACT Supreme Court

Clause 47's subsection 65(b) newly requires that the ACT Supreme Court cannot make an order that gives consent to psychiatric surgery being performed on a person who has not given informed consent to that surgery, unless the Court is satisfied that the person does not have decision-making capacity for giving that consent.

Section 65 of the Act also requires the Court to be satisfied of a number of other matters unrelated to the person's decision-making capacity, before it can make such an order.

3.1.3.6 Decision-making capacity and guardians

The Bill makes a number of amendments to the *Guardianship Act* to reflect the new role that guardians will have to provide substitute decisions. Guardians will have a new role in cases where a person does not have decision-making capacity and is compliant with treatment. The definition of 'having decision-making capacity' that is relevant here is the

one provided by this Bill's new section 7, not any definition under the *Guardianship Act*.

However, a guardian is not entitled to give consent to treatment for electroconvulsive therapy or psychiatric surgery, both remain prescribed treatments, or decide anything for the person that is contrary to any determinations or decisions made in relation to the person by the care coordinator under the community care order or any related restriction order.

Clause 128's subsection 142(1A)(a) newly allows a guardian *appointed* under the *Guardianship Act* to make decisions for a person with a mental disorder or illness, and give consent for their treatment for mental illness, if the person has no decision-making capacity, but expresses willingness to receive the treatment.

3.2 Clauses grounded in health research and the right to health

The Bill was informed by a body of research that has developed since the commencement of the Act. In summary, it shows that:

- a person's future capacities for recovery can be cumulatively diminished if they experience long periods of untreated mental illness, and
- a person may experience substantially shorter periods of illness, and less related, long-term disability, if the time between the onset of their illness and evidence-based treatment of it is reduced.[10]

This research demonstrates the necessity for timely, evidence-based treatment of people's mental illnesses.

In doing so, it points to how the *Mental Health (Treatment and Care) Act 1994* should lead the services it covers to assist people to secure the right to 'the highest attainable standard of physical and mental health' established by Article 12 of the International Covenant on Economic,

[10] See, for example, Dunitz, Martin and McGlashan, T.H. (1999) 'Duration of untreated psychosis in first-episode schizophrenia: marker or determinant of course?', *Biological Psychiatry*, Vol. 46, pp.899-907; McGorry, P.D., Purcell, R., Hickie, I.B., Jorm, A.F (2007) 'Investing in youth mental health is a best buy', *Medical Journal of Australia*, Vol. 187, pp.5-7; Norman, R.M. and Malla, A.K. (2001) 'Duration of untreated psychosis: A critical examination of the concept and its importance', *Psychological Medicine*, Vol. 31, pp.381-400.

Social and Cultural Rights (1966).[11]

This is notwithstanding that a range of other ACT statutes, policies and programs contribute to people accessing the right to 'the highest attainable standard of physical and mental health'. These include, for example, housing assistance programs, policies for the prevention and remediation of environmental pollution, and legislation for work health and safety. It is also despite the international right to health not being a right to be healthy.

In 2000, the United Nations Committee on Economic, Social and Cultural Rights made a resolution on the right to 'the highest attainable standard of physical and mental health' to assist state parties to interpret Article 12 of the International Covenant on Economic, Social and Cultural Rights.

As the Resolution underscores, the 'drafting history' and 'express words' of the right make clear that not only is it 'not confined to the right to health care', it is also embracing of the 'socio-economic factors that promote conditions in which people can lead a healthy life' such as 'housing' and a 'healthy environment'.[12] Further, states are not, and cannot be, responsible for every aspect of a person being healthy, because a person's health is always determined, to varying degrees, by their genetic make-up and lifestyle choices.[13]

There are two major connections between the mental health research findings on the need for mental health services to provide timely responses to people's mental illnesses, discussed above, and the right. One is that the 2000 Resolution proclaims that the right includes obligations to provide '*timely* and appropriate health care',[14] and, more specifically '*timely access* to basic preventive, curative, rehabilitative

[11] The United Nations International Covenant on Economic, Social and Cultural Rights. Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 3 January 1976, in accordance with Article 27 <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>, accessed 13 September 2013.

[12] United Nations Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12)*, 22nd sess, UN Doc E/C.12/2000/4 (11 August 2000), para. 4.

[13] ibid., para. 8.

[14] ibid., para. 11.

health services and health education'[15] (emphasis added).

Another is that the Resolution emphasises that one of the 'essential elements' of the right to health is the 'accessibility' of that right, 'in all its forms', including in the form of 'health-care facilities' and 'services'.[16]

The right, and the 2000 Resolution on it, is authoritative international law, when it comes to interpretation of the Bill and the amended Act. As the United Nations Special Rapporteur on the right to the highest attainable standard of health has observed, the right has migrated 'from the margins to the human rights mainstream'.[17]

Since it was declared, in 1996, in the International Covenant on Economic, Social and Cultural Rights, it has been codified in multiple articles of numerous group-specific treaties, including:

- Articles 5(e)(iv) and 5(d)(vii) of the International Convention on the Elimination of all Forms of Racial Discrimination (1966);
- Articles 11(1)(f), 12, and 14(2)(b) of the International Convention on the Elimination of all Forms of Discrimination Against Women (1979)', and
- Articles 24, for all children, and Articles 3(3), 17, 23, 25, 32 and 283 (3), 17, 23, 25, 32 and 28 for especially vulnerable groups of children, in the International Convention on the Rights of the Child (1989).[18]

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[15] ibid., para. 17.

[16] ibid., para. 12.

[17] United Nations Special Rapporteur on the right to the highest attainable standard of health, Hunt, Paul (2006) 'The human right to the highest attainable standard of health: new opportunities and challenges', *Transactions of the Royal Society of Tropical Medicine and Hygiene* (2006) 100, pp.603—607, p.604.

[18] *Universal Declaration of Human Rights*, Adopted by General Assembly Resolution 217 A(III) of 10 December 1948; International Convention on the Elimination of all Forms of Racial Discrimination, G.A. Res. 20/2106; UN GAOR 2106 (X) 1966: U.N.T.S. 195; International Convention on the Elimination of all Forms of Discrimination Against Women, G.A. Res. 34/180, UN GAOR, 34th Sess., Supp. No. 46 at 193 UN Doc.A/34/46 1979; International Convention on the Rights of the Child, G.A. Res. 44/25, UN GAOR, 44th Sess., Supp. No. 49, at 166, UN Doc. A/44/25 1989.

There are other instruments that are relevant to the right to health. Further standards are referenced in World Health Organisation, *25 Questions and Answers on Health and Human Rights*, Health and Human Rights Publications Series Issue 1, 2002; and G. Alfredsson and K. Tomasevski (eds.), *A Thematic Guide to Documents on Health and*

The right to health is also explicitly proclaimed in many regional human rights treaties[19] and over sixty national constitutions[20]. Case law affirming the right has proliferated from these Conventions, regional treaties and national constitutions.[21]

Human Rights: Global and Regional Standards Adopted by Intergovernmental Organizations, International Non-governmental Organizations, and Professional Associations (Nijhoff, 1998).

[19] See, for example, Article 16 of the African Charter on Human and Peoples' Rights; Article 14 of the African Charter on the Rights and Welfare of the Child ; Article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, known as the 'Protocol of San Salvador'; and Article 11 of the European Social Charter.

[20] United Nations Commission on Human Rights (2003) *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health: Report of the Special Rapporteur*, Paul Hunt, submitted in accordance with Commission resolution 2002/31, E/CN.4/2003/58, 13 February 2003, p.7.

[21] *Mariela Viceconte v Argentinian Ministry of Health and Social* Welfare (Poder *Judicial de la Nación*, Causa no. 31.777/96, 2 June 1998) was a case involving a claim based on Article 12(2)(c) of the International Covenant on Economic, Social and Cultural Rights in relation to the Argentine Government's failure to arrange the production of a vaccine against Argentine hemorrhagic fever.

Article 12(2)(c) provides that the steps States parties should take in achieving the full enjoyment of the right to health include those 'necessary for ... (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases'. The Federal Administrative Court of Appeals of Argentina found a violation of the International Covenant on Economic, Social and Cultural Rights and ordered the State to arrange for production of the vaccine.

Similarly, a decision of the Supreme Court of Argentina held that the right to health in the International Covenant on Economic, Social and Cultural Rights and Argentina's Constitution required the Government to continue to provide the drug to the child (*Campodónico de Beviacqua, Ana Carina c/ Ministerio de Salud y Acción Social – Secretaría de Programas de Salud y Banco de Drogas Neoplásicas*, Supreme Court of Argentina, 24 October 2000, No. 823 XXXV).

In *López Ostra v. Spain*, the European Court of Human Rights found that environmental harm to human health may amount to a violation of the right to a home and family and private life (Application No. 16798/90, Court of Human Rights, 1994). In *International Commission of Jurists v. Portugal,* the European Committee of Social Rights found a breach of the European Social Charter and, in doing so, the Committee expressed concern that a significant number of children worked in sectors which 'may have negative consequences on the children's health as well as on their development' (Complaint 1/1998, European Committee of Social Rights, 1999).

In its admissibility decision in *Jorge Odir Miranda Cortez et al. v. El Salvador*, the Inter-American Commission on Human Rights held that while it was not competent to determine violations of article 10 (the right to health) of the Protocol of San Salvador, it would 'take into account the provisions related to the right to health in its analysis of the

While the United Nations Special Rapporteur on the Right to the Highest Attainable Standard of Health recommended, among other things, that an enforceable and justifiable right to health be enacted by the federal parliament, [22] there is currently no express right to health in the ACT *Human Rights Act 2004* or the Victorian *Charter of Human Rights and Responsibilities ACT 2006*, Australia's two statutory human rights charters. [23]

However, as Australia has ratified the abovementioned Covenant and Conventions that declare the right to health, consideration of the right is relevant to the interpretation of ACT statutes. For more on this, please see the discussion, in *5.2.2 International and local human rights law*.

3.2.1 Requirements related to medical examinations and assessments

Clause 11's new subsections 36ZC(3) and 36ZK(3) newly require a consultant psychiatrist, psychiatric registrar in consultation with a consultant psychiatrist, or another doctor in consultation with a consultant psychiatrist, to conduct four-hourly medical examinations of persons who are involuntarily secluded under the Act.

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merits of the case, pursuant to the provisions of articles 26 and 29 of the American Convention' (Inter-American Commission on Human Rights, Report No. 27/09 - Case 12.249, 20 March 2001, para. 47).

In the Ecuadorian case of *Mendoza and others v Ministry of Public Health and the Director of the HIV-AIDS National Programme*, the applicants, people living with HIV/AIDS, alleged violations of their constitutional right to health and the constitutional guarantee that public services for medical attention shall be free of charge for those persons that need it. The Court ruled that the State must take precautions to safeguard the right to health and that it forms part of the right to life (Tribunal Constitucional, 3ra. Sala, Ecuador, Resolucion No. 0749-2003-RA, 28 January 2004).

[22] United Nations Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Grover, Anand (2010), *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Addendum, Mission to Australia*, presented to the General Assembly on 3 June 2010, A/HRC/14/20/Add.4.

[23] *Charter of Human Rights and Responsibilities Act 2006* (Vic.) <http://www.legislation.vic.gov.au/Domino/Web_Notes/LDMS/LTObject_Store/ltobjst8.nsf/DDE300B846EED9C7CA257616000A3571/E42FBB83DE048B6FCA257C2F0015C5BB/$FILE/06-43aa011%20authorised.pdf>, accessed 13 January 2014.

Further, clause 12's:

- subsection 40(6) newly obliges the person in charge of an approved mental health facility to 'tell the public advocate, in writing, about any failure to give a subject person an initial examination within the time required under subsections 40(2) or 40(4) and the reasons for the failure';
- subsection 40(7) newly stipulates that an 'initial examination' means no less than examining the person 'in person' *and* considering 'the observations arising from the examination' and from 'any other reliable and relevant information about the subject persons' condition';
- subsection 41(1)(b) newly requires that people involuntarily detained under section 41 be examined by a second doctor who did not conduct the initial examination of them required by subsection 40(7), and
- subsection 41AA(1) newly mandates that a person detained at a facility under subsection 41(1) will be given a 'thorough' physical examination by a doctor *and* a psychiatric examination by a consultant psychiatrist, or by a psychiatric registrar in consultation with a consultant psychiatrist, or by another doctor in consultation with a consultant psychiatrist.

Please also see *7. What does each of the Bill clauses provide?*, for discussion of how the doctors' examinations mandated by clause 12's subsection 41(1)(b) exceed the relevant requirements of the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care,[24] international law created by the United Nations General Assembly, with Australia's full support, in 1991[25]. Subsection 41(1) empowers a doctor to involuntarily detain people in an approved mental health facility for a period not exceeding three days, in certain

[24] The United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care. Adopted by General Assembly resolution 46/119 of 17 December 1991 <http://www.ohchr.org/EN/ProfessionalInterest/Pages/PersonsWithMentalIllness.aspx>, accessed 13 September 2013.

[25] Mr Chris Sidoti, Australian Human Rights Commissioner 1995-2000, 'Mental Health For All: What's the Vision?', Speech to National Conference on Mental Health Services, Policy and Law Reform into the Twenty First Century, 13-14 February 1997, Newcastle, Australia <https://www.humanrights.gov.au/news/speeches/mental-health-all-whats-vision>, accessed 10 January 2014.

limited circumstances narrowly defined by the Bill.

The Bill inserts into the Act two new requirements regarding medical assessments for applications for mental health orders.

First, clause 11's subsection 36O(3)(a) requires that an application must be accompanied by a written statement by the relevant person addressing the criteria that the ACAT must consider in making a psychiatric treatment order under section 36V or a community care order under section 36ZD This is significant, here, because subsection 36V(2)(a) requires that the person has a mental illness and subsection 36ZD(2)(a) requires that the person has a mental disorder.

Second, clause 11's subsection 36Q(2) prescribes a new requirement pertaining to medical assessments. It is that before making a mental health order, the ACAT must consider how recently the assessment of the person was conducted.

Similarly, clause 43's subsection 48V(2) requires that before making a forensic mental health order, the ACAT must consider an assessment of the person and how recently the assessment was conducted.

3.2.2 Provisions enabling authorised ambulance paramedics to apprehend and remove a person

The following amendments newly enable authorised ambulance paramedics to apprehend a person and take them to an approved mental health or community care facility, in certain circumstances narrowly specified by the Act:

- clause 11's subsections 36ZO(3) and 36ZP(2);
- clause 12's subsection37(1), and
- clause 43's subsections 48ZT(5), 48ZW(5), 48ZX(3), 48ZY(2), and 48ZZU(2).

The Act currently empowers only doctors, mental health officers, and police officers to conduct this apprehension and removal.

The amendments will mean a police officer – who, by definition, is not a health professional – will not be the only lawful alternative to a doctor or a mental health officer, when a person needs to be apprehended and taken to a mental health or community care facility. Rather, authorised

ambulance paramedics will also be able to do this.

Frequently, it will be more appropriate for ambulance paramedics, rather than police officers, to fulfill this need.

The legislation, policy, and procedures that govern ambulance paramedics focus on delivering a health, rather than a law and order, service. Further, authoriziation of ambulance paramedics will enable the ambulabnce service to ensure that ambulance paramedics who provide this service are trained, practised and acculturated in how to therapeutically serve people who have mental illness/es and/or disorder/s.

People with mental illness/es and/or disorder/s can also be unnecessarily stigmatised by being apprehended and transported by police officers, rather than ambulance paramedics. They also cannot be given health care while they are being transported by police officers, whereas they can be while being transported by ambulance paramedics.

As declared by the *National Safe Transport Principles*, a document endorsed by the Australian Health Ministers' Advisory Council in April 2008:

- the transportation used to take a person who has, or appears to have, mental illness/es and/or disorder/s to therapeutic facilities 'should be considered as both a key mode of access to mental health care, and a site of care delivery', and
- police involvement in this 'should be a last resort' adopted 'only where it is consistent with their role for ensuring public (including the consumer's) safety'.[26]

None of the above is to suggest that health professionals, including ambulance paramedics, do not need to sometimes work with police officers to safely apprehend and transport a person to an approved mental health or community care facility.

This is necessary, at times, for the safety of the person and others around them. For example, the person's illness may manifest in potentially injurious behaviours that have proven unresponsive to the health

[26] Australian Health Ministers' Advisory Council (2008) *National Safe Transport Principles*, endorsed by the Council in April 2008.

professionals' de-escalation techniques.

3.2.3 Requirements to inform, or consult with, the person with the mental illness/es and/or disorder/s and certain other persons

In its General Comment No. 14 on the right to the highest attainable standard of health, the Committee on Economic, Social and Cultural Rights characterises the 'right to seek, receive and impart information and ideas concerning health issues' as both a foundation of the essential 'accessibility' element of the right to health, as well as a right provided by Article 19.2 of the International Covenant on Civil and Political Rights.[27]

Article 19.2 is reflected in subsection 16(2) of the ACT *Human Rights Act 2004*, which states that:

Everyone has the right to freedom of expression. This right includes the freedom to seek, receive and impart information and ideas of all kinds, regardless of borders, whether orally, in writing or in print, by way of art, or in another way chosen by him or her.

The following amendments proposed by the Bill, among others, newly require that the person with mental illness/es and/or disorders is given information or consulted, or that certain people account for whether they have consulted with the person:

- clause 11's Part 3.3 provisions, which compel the representative of the treating team to give information to the person to enable them to enter into an advance agreement or make an advance consent direction (explained above under *3.1.3.3 Nominated persons, advance agreements, and advance consent directions*);
- clause 11's subsection 36B(1), which requires the ACAT, in considering an assessment order under subsections 36A(a), 36A(b) or 36A(c), to take reasonable steps to give the person written notice that the ACAT is considering making them the subject of an assessment order, that an assessment may lead to a treatment order, and that if a treatment order is made the person's rights in respect of treatment will be

[27] Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12)*, 22nd sess, UN Doc E/C.12/2000/4 (11 August 2000), para. 12.

explained to them then;

- clause 11's 36D(4), which obliges the ACAT, in making an assessment order, to explain to the person, in a way they can understand, the effect of clause 11's section 36V, which provides for psychiatric treatment orders, or clause 11's section 36ZD which provides for community care orders, unless the ACAT is making an emergency assessment order under clause 11's section 36C;
- clause 11's subsection 36Z(5), which dictates that the chief psychiatrist will 'take all reasonable steps' to consult the person before making a determination on their treatment, care or support;
- clause 11's subsection 36Z(6), which requires the chief psychiatrist to record whether they consulted the person, after the chief psychiatrist makes a determination on the person, and if they did consult the person, what the person's views were, and if they did not, the reasons why not;
- clause 43's section 48ZD, which directs that the chief psychiatrist will, before giving treatment to a person under a forensic psychiatric treatment order, explain to the person the treatment's nature and effects, including side effects, in a way that the person is most likely to understand;
- clause 43's section 48ZK, which states that before a person is given treatment, care or support under a community care order, the care coordinator will explain to the person the nature and effects, including any side effects, of the treatment, care and support, in a way that the person is most likely to understand, and
- clause 43's subsection 48ZO, which declares, among other things, that as soon as practicable after imposing communication limits on a person who is subject to a forensic mental health order, the relevant official must explain to the person the nature and period of the limits, and the reasons for them, in a way the person is most likely to understand.

The Bill also contains many amendments that newly require that information be given to, or consultation undertaken with:

- people who have been statutorily charged with the care or supervision of a person with mental illness/es and/or disorders;

- people who have been lawfully appointed by a person to assist them in certain ways, and/or someone a person who is understood to be a person's carer, and
- people permitted to apply for an assessment order, because they believe, on reasonable grounds, that a person's health or safety is, or is likely to be, substantially at risk, due to their mental disorder or illness, or because they are doing, or are likely to do, serious harm to someone else.

These amendments include clause 11's subsection 36R, which states that before making a mental health order about a person, the ACAT must consult, as far as is practicable, the person's:

- attorney under the *Powers of Attorney Act 2006* (ACT), if the person has one;
- the person's nominated person, if they have one;
- the person's health attorney, if they have one;
- the chief psychiatrist or care-coordinator, if they are likely to be responsible for providing the treatment, care or support that the ACAT is proposing to order;
- the corrections director-general, if the person is a detainee, a person released on licence, or a person serving a community-based sentence;
- the director-general responsible for the supervision of the person under the *Bail Act 1992* , if the person is covered by a bail order that includes a condition that the person accept supervision under subsection 25(4)(e) or section 25A of the *Bail Act 1992*;
- the director-general responsible for the administration of the *Children and Young People Act 2008*, if the person is a child covered by a bail order that includes a condition that the child accept supervision under subsection 26(2) of the *Bail Act 1992*;
- the same director-general if the person is a young detainee or young offender serving a community-based sentence, and
- the assessment order applicant, where they were permitted to apply under part 4.1 of the Act, because they believed, on reasonable grounds, that the person is, or is likely to, substantially risk their health

and safety or seriously harm another, as a result of their mental illness or disorder.

Clause 11's subsection 36R(2) also imposes a new obligation on the ACAT. It is that before making a mental health order about a person, the ACAT must, if the ACAT has contact details for the person's carer, write to the carer that a hearing will be held about making the order and the carer may apply to the ACAT to attend the hearing and may make a submission regarding the order to the ACAT.

Clause 43's section 48W is the forensic psychiatric treatment orders equivalent of clause 11's subsection 36R(1).

For further explanation of these provisions, please see *7. What does each of the Bill clauses provide?*

3.3 Extended permissible period for involuntary detention

As the Act currently reads:

- under subsection 41(1), a doctor may authorise the involuntary detention and care of a person, at an approved mental health facility, for a period not exceeding three days, when factors that are narrowly defined by subsection 41(1) indicate that a person needs urgent treatment, care or support for their mental illness or disorder and they are refusing to receive it, and
- before the expiration of the authorisation under subsection 41(1), under subsection 41(2), a psychiatrist may apply to the ACAT for an order detaining the person for a further period not exceeding seven days.

Consequently, under the current section 41, a person may be involuntarily detained for a period of up to ten days total.

The Review concluded that the Act should be amended to state that the ACAT may order a further period of detention for a period not exceeding eleven days. This is an increase of four days on the maximum further period of detention the ACAT may currently order under section 41(3).

This means that under amended section 41, a person could be involuntarily detained for a period of up-to-fourteen days – up to three days authorised by the doctor plus the up-to-eleven days ordered by the

ACAT.

The Review determined that this increase in the maximum term of detention that the ACAT can initially order is necessary, because history shows that a person typically needs more time in treatment for their treating team to satisfactorily assess whether a psychiatrist needs to apply to the ACAT to make the person subject to a psychiatric treatment order. Under the subsection 36J(1)(a)(i) of the current Act and new section 36ZN(a)(i) in the Bill, such an order may have a term of up to six months.

To avoid a situation where there is no lawful authority to treat the person, if the treating team wishes to continue treatment, and the person continues to refuse consent, the application for the psychiatric treatment order must be made before the expiration of the order ACAT made under subsection 41(3).

Under the current section 41, when that ACAT order expires, the person can only have been at the mental health facility for a maximum of ten days. However, the treating team actually has only seven days in which to make a decision about whether to apply for an order. This is an outcome of sections 24 and 85 in the current Act which require the ACAT to have a hearing on each application for a psychiatric treatment order and to give certain parties three days written notice of the hearing respectively.

Both safeguards are preserved by the Bill's new sections 36S and 79A, respectively.

Even those people who ordinarily could effectively represent their views to the ACAT adequately, or could find and instruct a lawyer to do so, may not be able to after they have become unwell and have had ten days (or fewer) of treatment in the facility. The Act's criteria for the up-to-three day's doctor's authorisation and the ACAT order are such that the person is likely to have been quite unwell to have had either imposed on them.

Moreover, the section 41 process risks the ACAT having to make a longer term order than it might have, had the treating team had more time in which to observe the person's responses to treatment and had the person had more time in which to recover . It is intended that these risks will be mitigated by the new section 41 extension in the period permissible for

involuntary detention to give urgent treatment, care or support.

In recognition of how the ACAT is permitted to order the detention of persons for four more days by the new section 41, the Review resolved that the Act should mandate that:

- eighteen months after section 41 commences, the Minister responsible for the Act will invite the public to make submissions to the Minister's review of the further period permitted by subsection 41(3), and
- not later than two and a half years after section 41 commences, the Minister will lay a report on the review before the Legislative Assembly.

  The review will enble consideration of whether extending the maximum period of emergency detention has had the intended beneficial effect on the course of treatment, including possible reduction in the number of longer term orders, and improvement in the person's experience of care. Clause 126's new subsection 145A provides for this public review.

3.4 A new class of forensic mental health orders

Chapter 7 inserts a new chapter into the Act that applies to people with a mental illness or mental disorder who have come into contact with the criminal justice system referred to as forensic patients.

Chapter 7 establishes a new suite of 'forensic mental health orders' based on existing psychiatric treatment orders and community care orders made by ACAT and implemented by the chief psychiatrist for forensic psychiatric treatment orders and the care coordinator for the forensic community care orders.

The ACAT may make an order for a person:

- detained in a correctional centre or place of detention;
- serving a community-based sentence;
- required to submit to the jurisdiction of the ACAT by a court order made under the *Crimes Act 1900 (ACT)*, part 13 (Unfitness to Plead and Mental Impairment), and
- required to submit to the jurisdiction of the ACAT by a court order made under the *Crimes Act 1914 (Cwth)*, Part 1B (Federal Offenders).

The purposes of the new provisions are to:

- identify and provide for the care, treatment and support of people subject to criminal proceedings who are living with a mental illness or mental disorder;
- promote the least intrusive treatment and care of those people;
- ensure the safety of members of the community from the risk of serious harm, and
- provide a new scheme to allow relevant information about the person to be shared under appropriate controls with people who have been harmed by the person's conduct.

Chapter 7 also aims to provide appropriate oversight of and safeguards for how the treatment care and support of forensic patients is managed. The scheme will also facilitate appropriate service responses for forensic patients living in the community with support and supervision by relevant health, disability and/or justice services.

The criteria for the making of forensic mental health orders are broadly consistent with the criteria for the making of mental health orders under Part 5.

Before the ACAT can make a forensic mental health order it must be established that the person has a mental illness or mental disorder and ACAT must believe on reasonable grounds that the person:

- is doing or is likely to do serious harm to themselves or someone else; or
- is suffering or is likely to suffer serious mental or physical deterioration; and
- has seriously endangered or is likely to seriously endanger, public safety.

The ACAT must also be satisfied that the treatment, care or support is likely to reduce the risks to the person, another person or to public safety.

Finally, the ACAT must be satisfied that in the circumstances that a mental health order under part 5 should not be made and that the treatment, care and support cannot be adequately provided in a way that

would involve less restriction of the freedom of choice and movement of the person.

Forensic mental health orders can be distinguished from mental health orders in a number of key aspects.

First, forensic mental health orders do not include a criterion in relation to whether a person has decision making capacity but refuses treatment, care or support. Under amendments proposed in clauses 19 and 22, mental health orders may only be made for a person where the person does not have decision making capacity. Under the proposed amendments, a mental health order can also be made for a person with decision making capacity who refuses to consent where the harms or deterioration is of such a serious nature that it outweighs the person's right to refuse to consent.

The exclusion of decision making capacity as a criterion for forensic mental health orders is appropriate given the additional criterion of serious endangerment which is discussed immediately below.

In making a forensic mental health order, the ACAT must take into account whether the person consents, refuses to consent or has the decision-making capacity to consent, to the proposed treatment, care or support (see section 48Y(1)(b)).

The second distinguishing aspect for forensic mental health orders is that they are subject to a further criterion that the ACAT must believes on reasonable grounds that the person has seriously endangered or is likely to seriously endanger public safety (see sections 48ZA(2)(c) and 48ZH(2)(c)).

Serious endangerment is a matter for the ACAT to determine on the balance of probabilities and is not defined in the Bill. This criterion requires the ACAT to take a risk based approach to the question of serious danger presented to the public by the person.

The serious endangerment criterion is based on the criterion used in the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Victoria) where the court is required to take into consideration whether a person 'is likely to endanger...other people generally' when making varying or revoking a supervision order for the person under that Act (section 40 — Matters to which the court is to have regard).

In the recent decision of *NOM v DPP & Ors* [2012] VSCA 198, the Victorian Court of Appeal stated that:

The ordinary meaning of endangerment entails the concept of chance or risk. The terms of section 40(1)(c) requires a Court to assess whether a person is 'likely to endanger themselves or others'. This serves to emphasise that the focus is upon the extent of the chance, risk or peril of some harm materialising. If the harm or injury which is likely to result is substantial but the 'chance', 'risk' or 'peril' of it eventuating is minimal, then a person subject to a supervision order is not necessarily 'likely to endanger' himself or others under section 40(1)(c).

The Victorian Court of Appeal went on to quote with approval a 1998 decision of Eames J:

In my opinion, a conclusion that there is a less than 50% chance of violent behaviour if the reviewee is released might, in some cases, support a conclusion that the judge is satisfied that the safety of the public would be 'seriously endangered'. The risk of serious harm being done, were the anticipated danger to eventuate, may constitute a release to be a serious endangerment, on the balance of probabilities, even though the risk of the event happening was less than a 50% chance. Similarly, a very high risk of a relatively minor act occurring (for example, indecent exposure) might not constitute serious endangerment of the public.[28]

The third distinguishing aspect of forensic mental health orders is the increased role for the ACAT in determining certain treatment, care and support measures that may be provided to a person subject to an order.

The chief psychiatrist or care coordinator must inform the ACAT where they come to the view that a forensic mental health order could not be made or where it is considered that it is no longer necessary to detain the

[28] *In the matter of s35 Crimes (Mental Impairment and Unfitness to be Tried Act) 1997 In the matters of major reviews of: Derek Ernest Percy, Barbara Kay Farrell & 'RJO'* (Name suppressed). [1998] VSC 70 (18 September 1998): Other Victorian cases that have considered the meaning of section 40 can assist the ACAT to determine whether a person's circumstances meet the criterion at sections 48ZA(2)(c) and 48ZH(2)(c) see NOM v DPP & Ors [2012] VSCA 198 (24 August 2012); Re SKD [2009] VSC 363 (4 September 2009).

person subject to the order. The procedural requirements in part 7 require the ACAT to give notice to relevant people and to hold a hearing before determining whether the order should be revoked, varied or continued.

A key aspect of the increased role for ACAT is its new role with respect to the granting of leave for people detained under division 7.1.8. This division applies to a person detained at an approved mental health facility or approved community care facility under a forensic mental health order (discussed further below).

Only the ACAT may consider applications for leave where ACAT has ordered that a person must be detained under a forensic mental health order. The purpose of this measure is to ensure that all relevant factors are considered before allowing a person leave from an approved mental health or approved community care facility.

Where the ACAT has not ordered that a person must be detained and the Chief Psychiatrist or the Care Coordinate has determined that the person be detained at a facility, Chief Psychiatrist or the Care Coordinator may grant leave from the facility.

The final distinguishing aspects of forensic mental health orders are the:

- improved information sharing provisions (see new Part 7.2); and
- new entitlements for people entered onto the Affected Persons Register (see new Part 7.3).

A further new measure is the formal recognition of people accused of a federal offence found unfit to plead and/or acquitted because of a mental illness. Under the *Crimes Act 1914* (Cwth), part 1B a number of dispositions are available to the court where a person is found unfit to plead and acquitted because of a mental illness. In the case of serious offences, the primary mechanism for disposal of these cases involves placing the person in custody in prison or hospital. It is also possible for the court to order that the person be assessed for whether they require mental health treatment.

Chapter 7 clarifies the ACAT's jurisdiction with respect to people of accused of a federal offence where the court refers the person for assessment and treatment.

Human rights considerations regarding the new Chapter 7 are discussed at 6.7 below.

3.5 Correctional patients

Chapter 8 proposes a new scheme for the transfer of certain detainees with a mental illness from a correctional centre to an approved mental health facility. The chapter applies to detainees with a mental illness for whom a mental health order or a forensic mental health order cannot be made. This will apply to a detainee who has a mental illness, decision-making capacity and is consenting to treatment, care and support including transfer to the facility.

The purpose of this chapter is to safeguard the rights of correctional patients and to provide a legal classification for detainees whilst transferred to an approved mental health facility.

This chapter has been modelled on similar provisions dealing with correctional patients in the *Mental Health (Forensic Procedures) Act 1990* (NSW), part 5.

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.

The proposed new chapter 8 creates a 'corrections patient' classification for detainees who require transfer from a correctional centre to an approved 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 8 will allow for systems to be put in place, 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.

The chapter safeguards rights by supporting the transfer of correctional patients to an approved mental health facility in a timely manner thereby ensuring that their treatment, care and support needs are met in a way that is least restrictive or intrusive to them.

Chapter 8 proposes a further degree of scrutiny for the mental health needs of correctional patients. It is proposed that the ACAT take on the role of reviewing the detention of forensic patients transferred to an approved mental health facility.

Detainee is defined in the dictionary with reference to section 6 of the *Corrections Management Act 2007* (see clause 153).

Chapter 8 refers to correctional patients, defined as a person in relation to whom a transfer direction has been made. The transfer of correctional patients needs to occur as soon as practicable.

This chapter operates consistently with the *Corrections Management Act 2007*, section 54 (Transfers to health facilities) and the proposed new section in the Bill (section 54A, Transfer to mental health facility—transfer direction).

Human rights considerations regarding the new Chapter 8 are discussed at 6.8 below.

4. Who will these changes affect?

The 2012 ACT Chief Health Officer's Report required by section 10 of the *Public Health Act 1997* provides some insight into the multiplicity of people that the Bill will affect, if enacted.

Using the latest data available, the Report states that in 2007-08, 11.8 percent of the adult ACT population - over one in ten ACT adults - reported having a mental disorder that had been diagnosed by a doctor. 'Mental disorders', for the purposes of the Chief Health Officer's report, include depression, anxiety, and psychotic disorders such as

schizophrenia.[29]

The Report notes that people in the ACT receive mental health services through:

- stays at Canberra Hospital, Calvary Private Hospital, and community-based, live-in residences; and/or
- visits to community-based and hospital-based facilities that do not admit people for stays.[30]

Apart from these people receiving services, the reforms provided by the Bill will affect, among others:

- carers and close family members and friends of people with mental illness/es and/or disorder/s;
- others, such as lawyers and non-government organisations, who advocate for people with mental illness/es and/or disorder/s, or who advocate for carers of people with mental illness/es and/or disorder/s;
- people who deliver mental health treatment, care and support services, such as psychiatric nurses and psychiatrists, and other professionals, such as general practitioners and ambulance paramedics, who facilitate people's access to these services; and
- the ACAT and ACT Courts, and statutory offices, such as the Office of the ACT Public Advocate and the Office of the ACT Health Services Commissioner, which oversight how people receive these services.

5. Who and what informed these changes?

Two of the Bill's keystones were the Review consultation process and advances in policy and law regarding people with mental illness/es and/or disorder/s.

5.1 People with mental illness/es and/or disorder/s and supporters

The Review was conducted by the ACT Health Directorate and ACT Justice

[29] ACT (2012) *Australian Capital Territory's Chief Health Officer's Report 2012*, p.45 <http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1345781911&sid=>, accessed 13 January 2014.

[30] ibid., pp.69-70.

and Community Safety Directorate, in collaboration with a Review Advisory Committee. The Committee members were, in no particular order:

- people who have experienced mental illness/es and/or disorder/s, including representatives of the ACT Mental Health Consumers Network and Mental Health Consumer Consultants to the ACT Health Directorate;
- people who have been the primary carers of people with mental illnesses and/or disorders, including members of Carers ACT, a non-government organisation that advocates for society-wide supports of carers and delivers services to carers;
- the Executive Officer of the Mental Health Community Coalition of the ACT, the peak body for 'non-government organisations that offer recovery, early intervention, prevention, health promotion and community support services for people with a mental illness'[31] and representatives of some of the Coalition's member organisations;
- the Executive Officer of the Youth Coalition of the ACT, 'the peak youth affairs body in the ACT responsible for representing the interests of people aged between twelve and twenty-five and those who work with them';[32]
- a Sergeant from ACT Policing's Mental Health Liaison Unit;
- the Director of the Australian National University's Research School of Psychology;
- a representative of the ACT Medicare Local;
- representatives of relevant ACT Government units, such as the Criminal Law Policy Section in the Justice and Community Safety Directorate, the Mental Health Policy Section in the Health Directorate, and the Office of Children, Youth and Family Services in the Community Services Directorate;
- representatives of ACT government services that routinely serve people

[31] Mental Health Community Coalition ACT website home page <http://www.mhccact.org.au/cms/index.php>, accessed 12 July 2013.

[32] Youth Coalition of the ACT website homepage <http://www.youthcoalition.net/>, accessed 12 July 2013.

with mental illness/es and/or disorder/s, including the ACT Ambulance Service, ACT Corrections, and Disability ACT;

- ACT statutory officers who routinely serve people with mental illness/es and/or disorder/s, such as the Chief Psychiatrist, the Community Care Coordinator, the Public Advocate, the Victims of Crime Commissioner, the Human Rights Commissioner, the Health Services Commissioner, the Principal Official Visitor, and a representative of the Office of the ACT Director of Public Prosecutions;
- the ACT Courts Registrar; and
- the General President of the ACAT.

Throughout the Review, the Committee deliberated on the possible reforms to the Act in consultation with a range of people. To facilitate this process, it widely circulated several publications, including:

- *The review of the ACT Mental Health (Treatment and Care) Act 1994 Discussion Paper* (July 2006), the *Options Paper* (November 2007), and the *Framework Paper* (November 2009), which were widely distributed in paper copies and on the world wide web by the Health Directorate;[33]
- the *First Exposure Draft of the ACT Mental Health (Treatment and Care) Amendment Bill* and *Explanatory Statement* (August 2012) and *Second Exposure Draft of the ACT Mental Health (Treatment and Care) Amendment Bill* and the proposed changes and explanation (April 2013), which were also widely distributed in paper copies and on the world wide web by the Health Directorate;[34] and
- the submissions made on the first and second exposure drafts of the Amendment Bill, which the Health Directorate published on the world wide web, unless a submitter requested that their submission be kept

[33] ACT (2006) *The review of the ACT* Mental Health (Treatment and Care) Act 1994 *Discussion Paper,* July 2006; ACT (2007) *The review of the ACT* Mental Health (Treatment and Care) Act 1994 *Options Paper,* November; and ACT (2009) *The review of the ACT* Mental Health (Treatment and Care) Act 1994 *Framework Paper,* November 2009.

[34] ACT Health Directorate web page entitled 'Review of the Mental Health (Treatment and Care) Act 1994 <http://health.act.gov.au/consumer-information/community-consultation/review-of-the-mental-health-treatment-and-care-act-1994/review-of-the-mental-health-treatment-and-care-act-1994>, accessed 12 July 2013.

confidential[35].

The participation in the Review of people who have experienced mental illness/es and/or disorder/s was not only highly evident in the membership of the Committee and the content of the publications; it is also reflected in the submissions and numerous Bill clauses that are based on the rights of people with mental illness/es and/or disorder/s.

Accordingly, this participation has conformed with the United Nations exhortation to incorporate people with mental illness/es and/or disorder/s in all public decision-making that will impact on them. The United Nations declares that such participation is necessary in:

- Article 4(3) of the Convention on the Rights of People with Disabilities and strongly encourages it in Convention Articles 1, 3, 19, 24, 16 19, 30 and 34 and preamble paragraphs e, k, m and y,[36] and
- United Nations Economic and Social Council General Comment No. 14 on the right to the highest attainable standard of physical and mental health (2000), a right established by Article 12 of the International Covenant on Economic, Social and Cultural Rights, as discussed under *5.2.2.2 Other international human rights instruments*.[37]

5.2 Contemporary developments in policy and law

The Review's aim has been to ensure the Act 'will meet the needs of our community and bring Canberra's legislation into line' with 'reforms happening here and in other Australian states and globally'.[38]

These reforms are changes to statutes and policies about mental health and about human rights generally. They are discussed below to engender understanding of the Bill's purposes. As noted earlier, the law requires

[35] ibid.

[36] The United Nations Convention on the Rights of Persons with Disabilities was opened for signature on 30 March 2007 (A/RES/61/106, Annex I <http://www2.ohchr.org/english/law/disabilities-convention.htm>, accessed 30 September 2013). Australia signed the Convention on 30 March 2007.

[37] ibid., para. 12.

[38] ACT Health Directorate web page entitled 'Review of the Mental Health (Treatment and Care) Act 1994 <http://health.act.gov.au/consumer-information/community-consultation/review-of-the-mental-health-treatment-and-care-act-1994/review-of-the-mental-health-treatment-and-care-act-1994>, accessed 12 July 2013.

the interpretation of the amendments to be consistent with the amendments' purposes.

5.2.1 Policies and legislation expressly addressing mental health

In 1991, the Health Ministers of the Commonwealth and all of the states and territories of Australia adopted the *Mental Health statement of rights and responsibilities: Report of the Mental Health Consumer Outcomes Task Force* ('the National Statement'). The National Statement was also the outcome of consultations with 'consumer and professional groups concerned with mental health'.[39]

It is based on the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care,[40] international law created by the United Nations General Assembly, with Australia's full support, in 1991 ('the United Nations Mental Health Principles')[41].

The National Statement declares, among other things, that the consumer, in all States and Territories, has the right to have mental health legislation that is reviewed and updated and that affirms the fundamental rights and responsibilities contained in the Statement.[42]

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[39] Commonwealth of Australia (2000) *Mental Health statement of rights and responsibilities: Report of the Mental Health Consumer Outcomes Task Force*. Adopted by The Australian Health Ministers, March 1991, p.13 <http://www.health.gov.au/internet/main/publishing.nsf/Content/1FE72FD78779BB44CA2572060026BC9E/$File/rights.pdf>, accessed 13 September 2013.

[40] The United Nations Principles for the protection of persons with mental illness and the improvement of mental health care. Adopted by General Assembly resolution 46/119 of 17 December 1991 <http://www.ohchr.org/EN/ProfessionalInterest/Pages/PersonsWithMentalIllness.aspx>, accessed 13 September 2013.

[41] Mr Chris Sidoti, Australian Human Rights Commissioner 1995-2000, 'Mental Health For All: What's the Vision?', Speech to National Conference on Mental Health Services, Policy and Law Reform into the Twenty First Century, 13-14 February 1997, Newcastle, Australia <https://www.humanrights.gov.au/news/speeches/mental-health-all-whats-vision>, accessed 10 January 2014.

[42] Commonwealth of Australia (2000) *Mental Health statement of rights and responsibilities: Report of the Mental Health Consumer Outcomes Task Force*. Adopted by The Australian Health Ministers, March 1991, p.13 <http://www.health.gov.au/internet/main/publishing.nsf/Content/1FE72FD78779BB44CA2572060026BC9E/$File/rights.pdf>, accessed 13 September 2013.

The National Statement enunciates that the relevant rights and responsibilities turn on every person with mental illness/es and/or disorder/s being:

- respected for their individual human worth and dignity;
- included in decision making about their treatment and care; and
- provided with comprehensive information on their mental illness, services and treatments for it, and the mechanisms for review of decisions made about their treatment.[43]

All of Australia's Health Ministers, including the ACT's, agreed, in Australia's 1992 National Mental Health Plan, to make their respective mental health statutes consistent with both the National Statement and the United Nations Mental Health Principles.[44]

Accordingly, approximately two years after all the provisions of the *Mental Health (Treatment and Care) Act 1994* had commenced, a Rights Analysis Instrument was prepared to evaluate mental health legislation for the Australian Health Ministers' Advisory Council National Mental Health Working Group. This occurred in consultation with many groups, including people who had been accessing services, the (unpaid) personal carers of such people, and organisations that advocate for people with mental illness/es and/or disorder/s.

During 1998 and 1999, the ACT, and almost every other state and territory, applied the Instrument to its legislation. In doing so, the states and territories were guided by panels that included representatives of those groups named above. The ACT evaluation indicated that, in some significant respects, the *Mental Health (Treatment and Care) Act 1994* substantially complied with, and exceeded, and fell short of, the benchmarks in the United Nations Mental Health Principles and the

[43] Commonwealth of Australia (2000) *Mental Health statement of rights and responsibilities: Report of the Mental Health Consumer Outcomes Task Force*. Adopted by The Australian Health Ministers, March 1991, p.13 <http://www.health.gov.au/internet/main/publishing.nsf/Content/1FE72FD78779BB44CA2572060026BC9E/$File/rights.pdf>, accessed 13 September 2013.

[44] Commonwealth of Australia (1992) *National Mental Health Plan*, p.12 <http://www.health.gov.au/internet/main/publishing.nsf/Content/8E185E7F3B574CCFCA2572220005FF0D/$File/plan92.pdf>, accessed 13 September 2013.

National Statement.[45]

The *Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009-2014* declares that states' and territories' mental health legislation should be 'reviewed to ensure compliance with relevant national and international obligations and charters'.[46] The national and international obligations and charters that are relevant are enumerated in the next part.

5.2.2 International and local human rights law

The international human rights instruments that most informed the development of the Bill are all relevant to its interpretation for four main reasons.

First, subsection 31(1) of the *Human Rights Act 2004* states that:

International law, and the judgments of foreign and international courts and tribunals, relevant to a human right may be considered in interpreting the human right.

Second, the interpretation of this Bill, and of the legislation it amends, turns on interpretation of rights in the *Human Rights Act 2004*, due to section 30 of that Act. Section 30 requires that all ACT legislation be interpreted compatibly with the rights in the *Human Rights Act 2004*, insofar as that interpretation is consistent with the purpose of the legislation.

Third, much common law provides that Australia's international law obligations may inform the interpretation of any statute in Australia.[47] Justice Maxwell neatly summarised this common law, in the 2006

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[45] See, generally, Commonwealth of Australia (2000) *Application of Rights Analysis Instrument to Australian Mental Health Legislation: Report to Australian Health Ministers' Advisory Council Mental Health Working Group*, prepared by Dr Helen Watchirs <http://www.health.gov.au/internet/main/publishing.nsf/Content/360B8042750B3170CA2571F100079B16/$File/rights.pdf>, accessed 13 September 2013.

[46] Commonwealth of Australia (2009) *Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009-2014*, p.13 <http://www.health.gov.au/internet/main/publishing.nsf/content/360EB322114EC906CA2576700014A817/$File/plan09v2.pdf>, accessed 13 September 2013.

[47] See, generally, *Tomasevic v Travaglini* [2007] VSC 337; (2007) 17 VR 100, [73] <http://www.austlii.edu.au/au/cases/vic/VSC/2007/337.html>, accessed 13 September 2013.

Supreme Court of Victoria Court of Appeal case *Royal Women's Hospital v Medical Practitioners Board*:

the provisions of international treaties are relevant to statutory interpretation. In the absence of a clear statement of intention to the contrary, a statute (Commonwealth or State [and Territory]*) should be interpreted and applied, as far as its language permits, so that it conforms with Australia's obligations under a relevant treaty*.[48]

This statutory interpretation principle is not displaced by any provision of the *Human Rights Act 2004* or other ACT legislation.

Fourth, an overview of the instruments that directly informed the Bill will assist the reader to understand the next part's brief accounts of how Bill clauses that limit rights in the *Human Rights Act 2004* nevertheless meet that Act's subsection 28(1) requirement that rights 'be subject only to reasonable limits set by laws that can be demonstrably justified in a free and democratic society'.

This is for two reasons. First, subsection 28(2) of the *Human Rights Act 2004* mandates that the following considerations be addressed in determining whether limiting clauses pass the subsection 28(1) test:

- the nature of the right affected;
- the importance of the purpose of the limitation;
- the nature and extent of the limitation;
- the relationship between the limitation and its purpose; and
- any less restrictive means reasonably available to achieve the purpose the limitation seeks to achieve.

Second, clauses in the Bill that reflect rights in the instruments described below temper the Bill clauses that limit rights and, do so in a way that satisfies the subsection 28(2) considerations.

[48] *Royal Women's Hospital v Medical Practitioners Board of Victoria* [2006] VSCA 85 (20 April 2006) [2006] VSCA 85; (2006) 15 VR 22, [75] <http://www.austlii.edu.au/au/cases/vic/VSCA/2006/85.html>, accessed 13 September 2013.

5.2.2.1 United Nations Convention on the Rights of Persons with Disabilities

The United Nations Convention on the Rights of Persons with Disabilities is the most authoritative of the international instruments that expressly address the rights of people with mental illness/es and/or disorder/s. Consequently, it shaped the Bill more than any other international instrument.

Article 1 of the Convention states that its purpose is to 'promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities' and that they 'include those who have long-term physical, mental, intellectual or sensory impairments...'[49] These disabilities encompass mental illness and disorder as defined in the Bill.

The Convention entered into force in Australia on 16 August 2008, after Australia ratified it on 17 July 2008.[50] Because it has been ratified, it covers activities throughout Australia, including the ACT.

On 21 August 2009, Australia also acceded to the Optional Protocol to the Convention on the Rights of Persons with Disabilities.[51] The Optional Protocol allows the United Nations Committee on the Rights of Persons with Disabilities to receive communications from, or on behalf of, individuals, or groups of individuals, who are complaining of Convention violations by a State party.

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[49] The United Nations Optional Protocol to the Convention on the Rights of Persons with Disabilities UN Doc A/61/611. Article 1. <http://www.ohchr.org/EN/HRBodies/CRPD/Pages/OptionalProtocolRightsPersonsWithDisabilities.aspx>, accessed 13 September 2013. Accession indicates that the State consents to becoming a party to that treaty by depositing an 'instrument of accession'.

[50] The United Nations Convention on the Rights of Persons with Disabilities was opened for signature on 30 March 2007, A/RES/61/106, Annex I <http://www2.ohchr.org/english/law/disabilities-convention.htm>, accessed 13 September 2013. Australia ratified the Convention on 17 July 2008: Commonwealth Attorney-General's Department webpage on the *Convention on the Rights of Persons with Disabilities* <http://www.ag.gov.au/RightsAndProtections/HumanRights/Pages/UnitedNationsConventionontherightsofpersonswithdisabilities.aspx>, accessed 9 January 2014.

[51] Commonwealth Attorney-General's Department webpage on the Convention on the Rights of Persons with Disabilities <http://www.ag.gov.au/RightsAndProtections/HumanRights/Pages/UnitedNationsConventionontherightsofpersonswithdisabilities.aspx>, accessed 9 January 2014.

Many of the Bill's amendments are requirements that are entirely new to the Act and will reinforce observance of many of the Convention Articles in the ACT. As can be seen under *6.3.3 Bill provisions explicitly requiring that minimal restrictions are imposed on the person's liberty*, many of the Bill's provisions that will further align the *Mental Health (Treatment and Care) Act 1994* with the Convention are the section 6 Principles.

As section 6 states, the Principles 'must be taken into account' in exercising any function under the Act.

5.2.2.2 Other international human rights instruments

The Bill's development was also directly influenced by rights in several other instruments that Australia has ratified.[52] As noted earlier, these include:

- the right to the highest attainable standard of physical and mental health in Article 12 of the International Covenant on Economic, Social and Cultural Rights; and
- the right to 'health' in Article 5(d)(vii) of the Convention on the Elimination of all Forms of Racial Discrimination (1965), Article 12 of the Convention on the Elimination of all Forms of Discrimination Against Women (1979), and Article 24 of the Convention on the Rights of the Child (1989).

Some of the Bill's provisions that are markedly oriented towards fulfillment of these rights are canvassed under *3.2 Clauses grounded in health research and the right to health*.

The rights that directly informed the Bill also include:

- the right to freedom from cruel, inhuman or degrading treatment, provided by Article 7 of the International Covenant on Civil and Political

[52] Australia ratified the International Covenant on Civil and Political Rights on 13 August 1980; the International Covenant on Economic, Social and Cultural Rights on 10 December 1975; the Convention on the Elimination of all Forms of Racial Discrimination on 30 September 1975; the Convention on the Elimination of all Forms of Discrimination Against Women on 28 July 1983; the Convention on the Rights of the Child on 17 December 1990; and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment on 8 August 1989 (Department of Foreign Affairs and Trade webpage providing Australia's Treaties Database <http://www.info.dfat.gov.au/Info/Treaties/treaties.nsf>, accessed 10 January 2013).

Rights,[53] Article 37 of the Convention on the Rights of the Child,[54] and Article 2 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment[55], and mirrored in section 10 of the *Human Rights Act 2004*;

- the right to liberty and security of person, provided by Article 9 of the International Covenant on Civil and Political Rights and Article 37 of the Convention on the Rights of the Child, and mirrored in section 18 of the *Human Rights Act 2004*; and
- the right to be treated with respect for dignity and with humanity when deprived of liberty, provided by Article 10 of the International Covenant on Civil and Political Rights and Article 37 of the Convention on the Rights of the Child, and mirrored in subsection 19(1) of the *Human Rights Act 2004*.

These rights are similar to many in the Convention on the Rights of People with Disabilities that are listed in the last part along with examples of Bill clauses that are directed towards actualising them in the ACT and discussed in greater detail under 6.7.

The United Nations Mental Health Principles, mentioned earlier, also informed the Bill. The Principles give valuable guidance on how the rights in the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights apply to people with mental illness/es and/or disorder/s.

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[53] The United Nations International Covenant on Civil and Political Rights <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx>, accessed 13 September 2013. Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 23 March 1976, in accordance with Article 49.

[54] The United Nations Convention on the Rights of the Child <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx>, accessed 13 September 2013. Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989, entry into force 2 September 1990, in accordance with Article 49.

[55] The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx>, accessed 13 September 2013. Adopted and opened for signature, ratification and accession by General Assembly resolution 39/46 of 10 December 1984, entry into force 26 June 1987, in accordance with Article 27(1).

For example, Principle 9(1) states that people with a mental illness have the right to treatment 'in the least restrictive environment...appropriate to the patient's health needs and the need to protect the physical safety of others'. This Principle informs many of the Bill's provisions. For more on this, please see *6.3.3 Bill provisions explicitly requiring that minimal restrictions are imposed on the person's liberty*.

5.2.2.3 International instruments particularly relevant to juveniles and adults in correctional custody or subject to forensic orders

From the outset, it was understood that the Bill's amendments would apply to those people detained in the Alexander Maconochie Centre or the Bimberi Youth Justice Centre who are, or appear to be, in need of mental health treatment, care and support, as well as to people who are the subject of forensic mental health orders.

Consequently, the international human rights instruments that specifically pertain to juveniles and adults who are prisoners or forensic patients were kept in mind as the Bill clauses were formulated. These instruments include the United Nations Standard Minimum Rules for the Administration of Juvenile Justice made by a Resolution of the General Assembly in 1985.[56] They are known as The Beijing Rules.

Rule 26.2 declares that juveniles 'in institutions shall receive care, protection and all necessary assistance - social, educational, vocational, psychological, medical and physical - that they may require because of their age, sex and personality and in the interest of their wholesome development'. The Commentary, in the Rules, elaborates on Rule 26.2 by stating, among other things, that 'Medical and psychological assistance, in particular, are extremely important for institutionalized…mentally ill young persons'.

Principle 20(2) of the United Nations Mental Health Principles is relevant to both juveniles and adults in custody who are, or appear to be, in need of mental health treatment, care, and support. Principle 20(2) stipulates that all the Mental Health Principles apply to imprisoned people 'to the fullest extent possible, with only such limited modifications and

[56] A/RES/40/33, November 1985, 96th plenary meeting.

exceptions as are necessary in the circumstances'.

The United Nations Mental Health Principles are discussed briefly in the last two paragraphs of *5.2.2.2 Other international human rights instruments*, above.

The United Nations Standard Minimum Rules for the Treatment of Prisoners (1957) also apply to both juveniles and adults.[57] These Rules are the heart of international human rights law pertaining to prisoners. In a 1971 Resolution, the General Assembly invited states to implement and incorporate them into legislation.[58] Then, it highlighted the Rules in its 1975 Resolution that was the *Declaration on the Protection of Persons from being subjected to torture* and *other cruel, inhuman or degrading treatment* (1975).[59]

Rule 82 of the Standard Minimum Rules expressly addresses the needs of people with mental illness/es and/or disorder/s. It declares that:

(1) Persons who are found to be insane 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 specialized 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 United Nations Human Rights Committee has relied extensively on the Standard Minimum Rules to interpret Article 10 of the International Covenant on Civil and Political Rights. It has also emphasised that Article

[57] 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 13 May 1977.

[58] GA Res 2858 (XXVI) (1971).

[59] GA Res 3452 (XXX) (8 December 1975).

10 is a minimum standard that it is unacceptable for states to fail to meet.[60] Article 10 provides that all persons deprived of their liberty have a right to be treated 'with humanity and with respect for the inherent dignity of the human person'.[61] Subsection 19(1) of the *Human Rights Act 2004* mirrors Article 10.

The Council of Australian Governments' National Statement of Principles for Forensic Mental Health requires, at Principle 13, that state and territory forensic mental health legislation comply with the International Covenant on Civil and Political Rights and the United Nations Mental Health Principles.

The United Nations Human Rights Committee indicated in its General Comment 21 that in interpreting the International Covenant on Civil and Political Rights, it is relevant to consider the Standard Minimum Rules, as well as the following three instruments:[62]

- the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (1988);[63]
- the Code of Conduct for Law Enforcement Officials (1978);[64] and
- the Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1982).[65]

Further, authoritative human rights commentaries on international law for the protection of prisoners state that the Basic Principles for the Treatment of Prisoners (1990)[66] are the instrument that elaborates on the

[60] United Nations Human Rights Committee General Comment 21, para. 4.

[61] Giffard, Camille (2002) 'International human rights law applicable to prisoners', in David Brown and Meredith Wilkie (eds) *Prisoners as Citizens: Human rights in Australian prisons*, The Federation Press, Sydney, Australia, p.190.

[62] General Comment 21, Article 10, UN Doc HRI\GEN\1\Rev.1.

[63] GA Res A43/173, UN Doc A/Res/43/173 (1988).

[64] GA Res 34/169, annex, 34 U.N. GAOR Supp. (No. 46) at 186, U.N. Doc. A/34/46 (1979).

[65] GA Res 37/194, annex, 37 U.N. GAOR Supp. (No. 51) at 211, U.N. Doc. A/37/51 (1982).

[66] GA Res 45/111, UN Doc A/Res/45/111 (1990).

meaning of the Standard Minimum Rules. This elaboration, includes, for example, Basic Principle 9 which states that 'Prisoners should have access to the health services available in the country without discrimination on the grounds of their legal status'.[67]

6. What features of the Bill show how the *Human Rights Act 2004* is engaged? Discuss

The following summarises the main features of the Bill that engage with the *Human Rights Act 2004*. Please also see that the human rights law dimensions of some of these clauses are elaborated on further under *7. What does each of the Bill clauses provide?*, below.

If the Bill is enacted, it will further the compatibility of the Act with human rights law, by:

- strengthening the current criteria for apprehension, removal, assessment, detention, treatment, and care, and review rights;
- extending these criteria, and review rights, to forensic and correctional patients; and
- establishing some new, extra criteria and review rights, for the exercise of powers under the Act.
- instituting new principles that bind the exercise of all functions under the Act.

6.1 ACT Civil and Administrative Tribunal and the right to a fair trial

The Bill, like the current Act, contains many provisions that enable the ACAT to make mental health and forensic mental health orders. These include, but are not limited to:

- clause 11's section 36A, and section 36C, which respectively empower the ACAT to make assessment and emergency assessment orders;
- clause 11's section 36G, which enables the ACAT to make removal orders to conduct assessments;

[67] Basic Principles for the Treatment of Prisoners, GA Res 45/111, UNGAOR, 68th plen mtg, UN Doc Res A/RES/45/111, 1990.

- clause 11's sections 36V and 36X, which respectively permit the ACAT to make psychiatric treatment orders and to make restriction orders with psychiatric treatment orders;
- clause 11's sections 36ZD and 36ZF, which respectively state that the ACAT can make community care orders and to make restriction orders with community care orders;
- clause 12's subsection 41(5), which permits the ACAT to extend the involuntary detention of a person that was initially authorised by a doctor to urgently treat a person; and
- clause 43's sections 48ZA and 48ZH which respectively enable the ACAT to make forensic psychiatric treatment orders and to make forensic community care orders.

These powers engage, among other provisions of the *Human Rights Act 2004*, its section 18 right to liberty and security of person, its section 13 right to freedom of movement, and its section 10 right to freedom from torture and cruel, inhuman or degrading treatment.

The ACAT is not a body that is, or holds itself out to be, a court. Its members have no tenure. Rather, they have various terms, depending on the kind of member they are appointed as, under section 98 of the *ACT Civil and Administrative Tribunal Act 2008* (ACAT Act). Further, as stated by section 8 of the ACAT Act, the ACAT is not bound by the rules of evidence.

This might raise the question of whether ACAT proceedings in relation to orders under the *Mental Health (Treatment and Care) Act 1994*, or any of its other proceedings, are compatible with the right to a fair trial provided by subsection 21(1) of the *Human Rights Act 2004*.

The United Kingdom's Mental Health Review Tribunal was questioned this way in *H v MHRT, North and East London Region* (2000),[68] a case brought before the High Court of the United Kingdom. The Court held that 'there was nothing unlawful [under the *Human Rights Act 1998* of the United Kingdom] about a tribunal system that was of an inquisitorial nature…'[69]

[68] unreported, Queen's Bench, 15 November 2000.

[69] Garwood-Gowers, A., Tingle, J., and Lewis, T. (2001) *Healthcare Law: The Impact of the Human Rights Act 2004* 1998*,* London, United Kingdom, p.182.

Principle 17 of the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care 1991 declares:

The review body shall be a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law. It shall, in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account.[70]

The Definitions section of these Principles defines 'review body' as 'the body established in accordance with Principle 17 to review the involuntary admission or retention of a patient in a mental health facility'.[71]

In this way, the United Nations Principles, particularly its Principle 17, expressly anticipates that administrative bodies that conform with due process rights will be arbiters of the treatment, care and support of persons who have, or appear to have, mental illness/es and/or disorder/s.

Certain provisions of the ACAT Act assure that ACAT is such a body, including when it comes to its proceedings on mental health and forensic mental health orders. These ACAT Act provisions include, but are not limited to:

- section 7, which requires the ACAT to 'ensure the procedures of the tribunal are as simple, quick, inexpensive and informal as is consistent with achieving justice and observe natural justice and procedural fairness';
- section 30, which allows a person appearing before the ACAT to be represented by a lawyer or another appropriate advocate;
- section 41A, which endows on a witness before the ACAT the same protection as a witness in a Supreme Court proceeding, and endows on a lawyer or anyone else representing a party before the ACAT, the same protection and immunity as a party to a Supreme Court proceeding or a barrister appearing for a party in the Supreme Court;
- sections 22B and 60, which dictate that the reasons for an ACAT

[70] United Nations General Assembly Resolution 46/119, 17 December 1991.

[71] ibid.

decision must be given to the parties to it, if they so request;

- section 90, which states that before allocating an ACAT member to an application, the general president must consider the nature and complexity of the matter, whether to allocate a member with special qualifications or experience, and any other consideration stated in an authorising law, such as the *Mental Health (Treatment and Care) Act 1994*;
- subsection 86(1), which enables a party to an application under the *Mental Health (Treatment and Care) Act 1994* to appeal to the Supreme Court on a question of fact or law; and
- section 83, which holds that if the parties to an application or appeal jointly apply to have the matter removed to the Supreme Court, the ACAT must order that it be so removed, and if one party to a matter applies to have it removed to the Supreme Court, the ACAT may, if it considers it appropriate, so order.

Further, certain Bill provisions, and certain provisions of the Act that the Bill preserves, also assure due process rights. These provisions include, but are not limited to:

- Bill clause 11's section 36S, which compels ACAT to hold a hearing before making anyone the subject of a mental health order;
- Bill clause 43's section 48X, which dictates that the ACAT will hold a hearing before making anyone the subject of a forensic mental health order;
- Bill clause 60's section 78, which reinforces section 90 of the ACAT Act by providing that for several kinds of proceedings authorised by the *Mental Health (Treatment and Care) Act 1994*, such as those on mental health and forensic mental health orders, the ACAT must be constituted by 'a presidential member and a non-presidential member with a relevant interest, experience or qualification'; and
- the current Act's section 141, which provides that an appeal to the ACT Supreme Court from an ACAT decision may be brought by someone in relation to whom the decision was made, or someone who appeared, or was entitled to appear, under subsection 80(1) of the current Act, the discrimination commissioner, or anyone else with the Court's leave.

6.2 Powers of apprehension, detention, movement restriction, and involuntary assessment, treatment, care and support

The Bill provides new powers, and preserves others in the current Act, to apprehend and detain a person and to restrict their movements to certain places and times. To see examples of the powers of apprehension and detention, please see:

- *3.2.2 Provisions enabling authorised ambulance paramedics to apprehend and remove a person,* earlier in this Explanatory Statement;
- *6.3.1 Provisions regarding health risks, medical necessity, and review*, below, and
- *6.3.4 Provisions that circumscribe specific powers of apprehension, removal, assessment, detention, restriction of movement, treatment, care and support*, below.

The powers enabling restrictions to be imposed on a person's movements include, but are not limited to, those:

- empowering ACAT to make, in relation to a person under a psychiatric treatment order, a restriction order which states that the person will live or be detained at a particular place, not approach a certain person or place, and not undertake stated activities, under clause 11's section 36X and subsection 36Y(1);
- allowing ACAT to make, in relation to a person under a community care order, a restriction order which states that the person will live or be detained at a particular place, not approach a certain person or place, and not undertake stated activities, under clause 11's section 36ZF and subsection 36ZG(1);
- permitting ACAT to require the same restrictions, but in the forensic psychiatric treatment order itself, under clause 43's subsections 48ZB(c) to 48ZB(e), all inclusive, and in the forensic community care order itself, under clause 43's subsections 48ZI(c) to 48ZI(e), all inclusive;
- dictating that the chief psychiatrist will determine whether a person under a psychiatric treatment order requires admission to an approved mental health facility and, for a person living in the community, the times when, and place where, they will attend, under clause 11's

subsection 36Z(2); and

- compelling the care coordinator to determine the times when, and the place where, a person under a community care order is required to attend to receive treatment, care or support, or undertake counselling, training, therapeutic or rehabilitation program, under clause 11's subsection 36ZH(2).

These powers of apprehension, detention and restrictions of movement:

- engage the section 10 right to protection from torture and cruel, inhuman or degrading treatment of the *Human Rights Act 2004*; and
- engage and limit the Act's section 18 right to liberty and security.

Please see the discussion on how international human rights law makes clear that administrative arrest and detention are covered by these rights under *6.5 Offences related to denying a person's rights to information and communications and the right of the accused to be presumed innocent*.

These powers also limit the Act's section 13 right stating: 'Everyone has the right to move freely within the ACT and to enter and leave it, and the freedom to choose his or her residence in the ACT'.

Various provisions of the Bill provide that, in certain limited circumstances, assessment, treatment, care or support can be provided to a person who did not consent to it, due to them not having the decision-making capacity to do so, or them having that capacity but refusing to consent. The Bill defines the limited circumstances in terms of, among other things, the risk of serious physical and/or mental harm to the person or someone else, if the person is not given the proposed treatment, care or support.

For instance, ACAT can order involuntary assessment, treatment, care or support, without the person's consent. For example, clause 11's new subsection 36V(2)(d), would add to the Act that where a person has the decision-making capacity to consent to the treatment, care or support, but refuses to give it:

- the ACAT can make them the subject of a psychiatric treatment order, provided the ACAT is satisfied that, among other things, the harm to the person or someone else, or the person's mental or physical deterioration, that is likely to result from their illness, is so serious as to

outweigh the person's right to refuse to consent.

Similarly, involuntary treatment, care or support can be determined under clause 11's:

- subsection 36Z(2), by the chief psychiatrist, in terms of the nature of treatment to be given to a person subject to a psychiatric treatment order; and
- subsection 36ZH(2), by the care coordinator, in terms of the counselling, training, therapeutic or rehabilitation program to be given to a person subject to a community care order.

Under clause 11's section 36ZC and subsection 36ZK, the chief psychiatrist or the care coordinator, respectively, may also authorise, under a person's order, their involuntary treatment, care and support. This can include involuntarily confining, restraining, secluding, or forcibly medicating them, in an approved mental health or community care facility, without their consent.

The ACT Supreme Court is also permitted by the Bill to give consent to treatment for a person. For instance, clause 47's subsection 65(b) newly requires that the Court cannot make an order that gives consent to psychiatric surgery – a very rare treatment - for a person who has not given informed consent to that surgery, unless the Court is satisfied that the person does not have decision-making capacity for giving that consent.

The Bill also enables a person's health attorney under the *Powers of Attorney Act 2006* to give consent to treatment, care or support for a person, if the health attorney is involved in the person's health matters. It also allows a person's guardian under the *Guardianship Act* to give consent to a person's treatment, care or support.

For example, clause 11's subsection 28(5) expressly allows a health professional to provide treatment, care or support other than that specified in a person's advance consent direction when the professional believes, on reasonable grounds, that it would be unsafe or inappropriate to comply with the direction, the person has no decision-making capacity (but does not resist the alternative treatment), and the person's guardian or health attorney consents to the proposed alternative.

These powers enabling involuntary, non-consensual medical assessment, treatment, care and support engage and limit subsection 10(2) of the *Human Rights Act 2004*, the right of a person to not be subjected to medical treatment without their free consent, part of the right to protection from torture and cruel, inhuman and degrading treatment.

6.3 Reasonableness and justifiability of these powers

There is a body of international human rights case law on such statutory powers of apprehension, removal, assessment, detention, restrictions on movements, and involuntary treatment, care and support, including forcible medication and involuntary confinement, restraint, and seclusion. That case law shows that so long as the powers meet certain requirements, they are demonstrably reasonable and justified, as required by the *Human Rights Act 2004*.[72]

The case law suggests that, at most, these requirements are that:

- powers for apprehension and removal are framed so that their exercise on a person is contingent on there being a serious risk to the health and safety of the person or other persons, or a serious risk to the person's best interests, where the risk stems from the person's mental illness/es and or disorders;
- powers of removal should be exercised to remove a person to a facility that is an appropriately therapeutic environment and then medically assess them relatively soon after – that is, the apprehension and removal powers need not be exercised only after the person's medical assessment;[73]
- powers of detention, restrictions on movements, or involuntary treatment, care and support are exercised only if appropriately qualified doctors, using clinically accepted methods, assess the person and establish what powers need to be exercised in respect of the person, and in what form and to what extent, because that is what is medical

[72] *Naumenko v. Ukraine* [2004] Application no. 42023/98, 10th February; *Herczegfalvy v. Austria* [1992] 15 EHRR 437; *R(B) v. S & Others* [2006] EWCA Civ 28; *R (Wilkinson) v. Broadmoor Special Hospital Authority* [2002] EWCA CIV 1545.

[73] *A (name withheld) v. New Zealand*, Communication No. 754/1997, U.N. Doc. CCPR/C/66/D/754/1997 (3 August 1999); *R (on the application of A) v. North West Lancashire Health Authority* [2000] 1 WLR 977; *A v. United Kingdom* (1981) 4 EHRR 188, European Court of Human Rights.

necessary, or in the person's best interests, due to the severity of their mental illness/es and/or disorder/s;[74]

- powers of detention, restrictions on movements, or involuntary treatment, care and support only continue to be exercised in respect of that person, if appropriately qualified doctors, using clinically accepted methods, periodically establish that that continues to be medically necessary or in the person's best interests, and in what form and to what extent, due to the severity of the person's mental illness/es and/or disorder/s;[75]
- the person has rights to review of the exercises of these powers by an administrative review body or court;
- these rights can be effectively exercised with relative speed after the initial imposition of the person's detention, restricted movements, or involuntary treatment, care and support and at regular, short intervals during their imposition;[76]
- the person is provided with medical care that is not significantly

[74] *Nevmerzhitsky v. Ukraine* [2005] Application no. 54825/00, 5th April; *Winterwerp v Netherlands* [1979] 2 EHHR, 387.

[75] ibid.

[76] For the international case law on this, see *A (name withheld) v. New Zealand*, Communication No. 754/1997, U.N. Doc. CCPR/C/66/D/754/1997 (3 August 1999); *Lines (Pauline) v UK* [1997] EHRLR, 297; *Roux (Joseph) v. United Kingdom* [1996] 22 EHRR, CD 196; *Johnson (Stanley) v. United Kingdom* [1997] EHRLR, 105; and *E v Norway* [1990] 17 EHRR 30.

Few cases in relation to the rights of people with mental illness/es and/or disorders have reached courts of law in Australia, other than in criminal cases that involve fitness to stand trial arguments and insanity pleas. An important exception to this rule was *In the Matter of XY* (1992) 2 MHRBD 501 (decided by Victorian Court of Appeal on 6 March 1992). The Court decided, in this case, that a person who had been involuntarily detained in a technically incorrect way, under the relevant legislation, still had a right of review of their detention by the Victorian Mental Health Review Board.

In deciding that the Board had this jurisdiction, the Supreme Court had no overt recourse to international or local human rights law. Nonetheless, it is an Australian precedent from an appellate court that endows a right on persons to have the propriety of their detention, under mental health legislation, reviewed by an administrative review body. Further, the case stipulates that this right of review remains, even when the original decision to detain was made incorrectly under certain statutory provisions, and so can be said to have not been made under them, and the statutory entitlement to review states that a decision made under those provisions can be reviewed by the administrative review body.

substandard for their illness/es and/or disorder/s, during their detention, restricted movements, or involuntary treatment, care and support,[77] bearing in mind that the case law gives jurisdictions wide discretion to determine what level of medical care they can provide within their resources;[78]

- the person's removal, detention, movement restriction, and involuntary assessment, treatment, care and support, does not have the *object* of humiliating and debasing the person *and* does not result in severe,[79] adverse effects which are of a nature and degree that is incompatible with the section 10 *Human Rights Act 2004* protection against torture and cruel, inhuman and degrading treatment,[80] accounting for the person's particular personality and their 'vulnerability and their inability, in some cases, to complain coherently, or at all, about how they are being affected by any particular treatment'[81].

6.3.1 Provisions regarding health risks, medical necessity, and review

In the Bill, powers of apprehension, removal, assessment, detention, and involuntary treatment, care and support are circumscribed by narrowly specified and mandatory criteria regarding medical necessity and serious risk to the person's, or another person's, health and safety, including:

- the provisions enumerated under *6.1 ACT Civil and Administrative*

[77] *Hurtado v. Switzerland* [1994] Application No. 1754/90, 28 January; *Riviere v. France* (2006) Application no. 33834/03, 11th July; *Holomiov v. Moldova* [2006] Application no. 30649/05, 7th November; *Tanko v. Finland* (1994) Application no. 23634/94, unreported. However, a case of clinical negligence does not automatically bear out violation of the protection: *R (Howard) v. Health Secretary* [2002] 3 WLR 738, at 759.

[78] This on pain of violating the protection from torture and cruel, inhuman or degrading treatment, provided by several international instruments and section 10 of the *Human Rights Act 2004*: *Matencio v. France* [2004] Application no. 58749/00, 15th January; *Sentges v. Netherlands* (2003) Application no. 27677/02, 8th July; *R (on the application of A) v. North West Lancashire Health Authority, ex parte A* [2000] 1 WLR 977.

[79] *Ireland v. The United Kingdom* [1978] 2 EHRR 25; *Herczegfalvy v. Austria* [1992] 15 EHRR 437; *Kudla v. Poland* 30210/96 [2000] ECHR 512 (26 October 2000); *Pretty v. United Kingdom* [2002] 35 EHRR 1.

[80] *Keenan v. United Kingdom* 27229/95 (2001) ECHR 242.

[81] *Hurtado v. Switzerland* [1994] Application No. 1754/90, 28 January.

Tribunal and the right to a fair trial, which specify when the ACAT can and cannot make people subject to certain mental health and forensic mental health orders; and

- clause 11's subsections 36ZO(3) and 36ZP(2), clause 12's subsections 37(1) and clause 43's subsections 48ZT(5), 48ZW(5), 48ZX(3), 48ZY(2), and 48ZZR(2), which provide when mental health officers, doctors, authorised ambulance paramedics, and police officers are permitted to apprehend and remove a person to an approved facility.

Section 119 of the current Act provides that 'mental health officers' are people appointed by the Minister responsible for the *Mental Health (Treatment and Care) Act 1994* and that they must be a nurse, an authorised nurse practitioner, a registered psychologist, registered occupational therapist, or registered social worker. Clause 80 of the Bill refines the Act's definition of a 'psychologist' and a 'social worker'.

The Bill also newly compels doctors to perform certain kinds of medical examinations of a person at certain times and ACAT to consider medical assessments before, and in making, an order about a person.

This is explained under *3.2.1 Requirements related to medical examinations and assessments*, earlier.

Further, the Bill extensively provides for new rights of review of the exercise of detention and other powers under the Act. Many of these new rights are described under *6.1 ACT Civil and Administrative Tribunal and the right to a fair trial.* The Bill also preserves review rights that are currently in the Act.

6.3.2 Bill's provisions safeguarding the wishes and best interests of people, including children

The Bill's new provisions on:

- decision-making capacity, including those pertaining to consent, (discussed under *3.1.3 Decision-making capacity provisions)*; and
- information giving, seeking and consideration, (discussed under *3.2.3 Requirements to inform, or consult with, the person with the mental illness/es and/or disorder/s and certain other persons)*;

assist a person's treatment, care and support to meet the person's best

interests and make it more difficult for it to not accord with the person's wishes, except in limited circumstances expressly permitted by the Bill.

In so doing, the provisions significantly foster:

- observance of sections 9, 19 and 10 of the *Human Rights Act 2004* – the rights to life, humane treatment when deprived of liberty, and protection from torture and cruel, inhuman and degrading treatment, respectively; and, in turn
- tempered applications of the Bill's powers of apprehension, removal, assessment, detention, restrictions on movements, and involuntary assessment, treatment, care and support.

This can be potently demonstrated with those provisions on capacity, consent and information seeking and giving, which explicitly safeguard the welfare of any child about whom decisions are made under the Act. The term 'child' in the *Mental Health (Treatment and Care) Act 1994* and the Bill means an 'individual who is under 18 years old'. This definition is sourced from the *Legislation Act 2001*, because the Bill and the current Act do not define 'child'.

These particular provisions include some that require that the person/s with parental responsibility[82] for a child is/are, under clause 11's:

- subsection 36L(2)(a)(iv), given, by the person in charge of the facility, copies of an assessment of that child conducted pursuant to an ACAT assessment order, and that this occur as soon as practicable, but not later than seven days after the completion of the assessment;
- subsection 36R(1)(a), consulted by ACAT, as far as is practicable, before ACAT makes a mental health order on the child;
- subsection 36Z(5)(a)(ii), consulted by the chief psychiatrist, if possible, after the chief psychiatrist takes all reasonable steps to do so, before making a determination on the child under the child's psychiatric treatment order;
- subsection 36Z(7)(b), given a copy of the determination by the chief psychiatrist, as soon as practicable after the chief psychiatrist makes it;

[82] Division 1.3.2 of the *Children and Young People Act 2008* (ACT) provides for who has parental responsibility for children.

- subsection 36ZH(3)(a)(ii), consulted by the care coordinator, if possible after the care coordinator takes all reasonable steps to do so, before making a determination on the child under the child's community care order; and
- subsection 36ZH(5)(b), given a copy of the determination by the care coordinator, as soon as practicable after it is made.

Under clause 11's subsection 36Z(5)(b), the chief psychiatrist must take into account the views of the person/s with parental responsibility for the child, before making a determination under a psychiatric treatment order on the child. Similarly, clause 11's subsection 36ZH(3) declares that the care coordinator will take the views of the people with parental responsibility for the child into account, before making a determination under a community care order on the child.

Further, clause 11's subsections 36R(1)(i) and 36R(1)(j), respectively, compel the ACAT to consult the director-general of the directorate responsible for the *Children and Young People Act 2008*, before making a mental health order, if it would be in relation to:

- a child who is subject to a bail order that is conditional on the child accepting supervision under subsection 26(2) of the *Bail Act 1992* (ACT); or
- a young detainee or young offender serving a community-based sentence.

Clause 11's subsection 36T(1)(f) requires that the ACAT takes all of the views of the people with whom it is required to consult under section 36R.

The Bill provides for similar requirements in respect of a child who is subject to a forensic mental health order.[83]

All of these provisions regarding a child who is the subject of a mental health or forensic mental health order require decision-makers to give or seek certain information regarding the child to or from the person/s with parental responsibility for them or to consider that information before or while making certain decisions.

[83] See, for example, clause 43's subsection 48W(a), 48ZC(5)(a)(ii), 48ZC(7)(b), 48ZJ(4)(a)(ii), and 48ZJ(5)(b).

By requiring this virtuous circle of information, the Bill makes it more probable that decisions made, and activities conducted under the Act, that relate to a child, will align with Article 7 of the International Covenant on Civil and Political Rights. Article 7 accords primacy to the best interests of each child in all actions that relate to the child. Similarly, subsection 11(2) of the *Human Rights Act 2004*, declares, among other things, that: 'Every child has the right to the protection needed by the child…'

This is in harmony with the large corpus of international human rights case law that recognises parents have the right to be involved in important decisions concerning their children.[84] This resonates strongly with the subsection 11(1) protection of the family in the *Human Rights Act 2004*.

Having said that, the provisions that protect a parent's right to participate in decision-making about their child, do not stand alone, but most operate with certain other Bill provisions.

These other provisions mandate that certain decision-makers consider the child's views about, and their consent, or withheld consent, to, treatment, care and support. For example, clause 11's:

- subsection 36T(1)(b) compels the ACAT to take into account whether the person consents, refuses to consent, or has the decision-making capacity to consent, to proposed treatment, care or support, when making a mental health order about them;
- subsection 36T(1)(c) obliges the ACAT to take into account 'the views and wishes of the person', in so far as they can be found out, when making a mental health order on a person;
- subsection 36Z(5)(a)(i) requires the chief psychiatrist to take all reasonable steps to consult with the person who is the subject of the psychiatric treatment order before making a determination on them;
- subsection 36Z(5)(b) dictates that the chief psychiatrist will take the views of the person into account, if they were obtained;
- subsection 36ZH(3)(a)(i) mandates that the care coordinator will take all reasonable steps to consult with the person who is the subject of the community care order before making a determination on them; and

[84] See, for example, *W v United Kingdom* (1987) 10 EHRR 29.

- subsection 36ZH(3)(c) dictates that the care coordinator will take the views of the person into account, if they were obtained.

Similar provisions provided by clause 43 require the same decision-makers to turn their respective minds to:

- seeking and considering the views of an person on making them the subject of a forensic mental health order[85] or a determination under such an order[86], and
- whether the person consents, or withholds consent, to certain treatment, care and support[87].

Bill provisions requiring consultation with a person apply as much to a person who is a child as they do to an adult, even though the same or neighbouring provisions require consultation with the person/s who have parental responsibility for the child.

Second, the Bill's provisions regarding people with parental responsibility for a child must also be obeyed *along with* those provisions requiring certain people to inquire into, support, or otherwise be responsive to, a person's decision-making capacity to consent to matters regarding their treatment, care and support, even when the person is a child. These provisions are described in some detail under *3.1.3 Decision-making capacity provisions* and *7. What does each of the Bill clauses provide?*

These first and second kinds of provisions enabling children's participation in decision-making about themselves are responses to, among other things, the significant case law on the decision-making capacity of children to consent to medical treatments, including:.

- The House of Lords decision *Gillick v West Norfolk and Wisbech Area*

[85] See, for example, subsection 48Y(1)(c) requiring ACAT to take into account the views and wishes of the person, so far as they can be found out, in making a forensic mental health order.

[86] See, for example, 48ZJ(3)(b)(i) requiring the community care coordinator to take all reasonable steps to consult the person, before making a determination on them under a forensic community care order.

[87] See, for example, subsection 48Y(1)(b) requiring ACAT to take into account whether the person consents, refuses to consent, or has the decision-making capacity to consent, to the proposed treatment, care or support, in making a forensic mental health order.

Health Authority (1986)[88]- regarded as the precedent in the common law world on the right of a person under the age of eighteen years of age to determine for themselves what medical interventions they will receive. It holds that young people who have sufficient intelligence and understanding to fully comprehend what is involved in a proposed medical intervention also have the capacity to consent to it.

- The High Court of Australia 1992 decision in Marion's Case.[89]
- *In Re R (A Minor) (Wardship: Consent to Treatment)* (1992)[90] *Re W* (1992)[91].
- *Director General*, *New South Wales Department of Community Services v Y* (1999).[92] in which the New South Wales Supreme Court ordered that a young person would receive anorexia treatment, even though she was refusing it.
- *Re Heather* (2003),in which the New South Wales Supreme Court

[88] [1986] AC 112. This ruling has become the touchstone for Australian legislators, jurists,[88] and health professionals[88] deliberating on children's decision-making capacity to consent to medical interventions, even when these deliberations end in overriding the wishes of so-called 'Gillick-competent children.'

For a contemporary exposition of Australian courts' treatment of the Gillick principles, please see Trowse, Pip (2010) 'Refusal of medical treatment: a child's prerogative?', *Queensland University of Technology Law and Justice Journal*, vol.10, no.2, pp.191-212

See State of Victoria (2013) *Decision-making principles for the care of infants, children and adolescents with intersex conditions*, February http://docs.health.vic.gov.au/docs/0D331CCA75EE85ACA257B1800707957/$FILE/PDF%20Final%20Intersex%20Conditions%20Resource.pdf, accessed 14 January 2014; Australia and New Zealand Association of Paediatric Surgeons, Child Health Division of The Royal Australasian College of Physicians (2010) *Recommendations For Bariatric Surgery In Adolescents in Australia and New Zealand: A position paper from the Australian and New Zealand: A position paper from the Australian and New Zealand Association of Paediatric Surgeons, the Obesity Surgery Society of Australia and New Zealand Association of Paediatrics & Child Health Division of The Royal Australasian College of Physicians*, March < , accessed 14 January 2014.< www.racp.edu.au/index.cfm?objectid=64DA592F-9F31-E67C-CDB308F5BF-9F31-E67C-CDB308F5BF17A086 >

[89] See, for example, in *Secretary, Department of Health and Community Services v JWB and SMB* (1992) 175 CLR 218.

[90] [1993] 1 FLR 386.

[91] [1992] 3 WLR 758.

[92] [1999] NSWSC 644.

overruled a child's decision to withhold consent to chemotherapy, diagnostic tests, and other medical procedures ancillary to chemotherapy.[93]

6.3.3 Bill provisions explicitly requiring that minimal restrictions are imposed on the person's liberty

Many of the Bill's provisions are explicitly directed towards ensuring that the person's liberty is interfered with by detention and treatment to the least extent commensurate with them receiving the treatment, care or support they need to prevent their health and safety, or others', from being seriously compromised.

These Bill provisions include, but are not limited to:

- clause 11's subsection 5(c), which states that one of the Objects of the Act is to 'ensure that people with a mental disorder or mental illness receive assessment and treatment, care or support in a way that is least restrictive or intrusive to them';
- clause 11's subsection 36T(1)(g), which compels the ACAT to take into account when it is making any mental health order 'that any restrictions placed on the person should be the minimum necessary for the safe and effective care of the person';
- clause 11's subsections 36V(2)(g), which dictates that the ACAT may only make a psychiatric treatment order, if it is satisfied that the treatment, care or support to be provided under the order cannot be adequately provided in another way that would involve less restriction of the person's freedom of choice and movement;
- clause 11's 36X(b), which binds the ACAT to not making a restriction order with a psychiatric treatment order unless the treatment, care or support to be provided under the restriction order cannot be adequately provided in another way that would involve less restriction of the person's freedom of choice and movement;
- clause 11's subsection 36ZD(2)(h), which declares that the ACAT cannot make a community care order, unless it is satisfied that the treatment, care or support to be provided under it cannot be

[93] [2003] NSWSC 532.

adequately provided in another way that would involve less restriction of the person's freedom of choice and movement;

- clause 11's subsection 36ZF(b), which bars the ACAT making a restriction order with a community care order unless the treatment, care or support to be provided under the restriction order cannot be adequately provided in another way that would involve less restriction of the person's freedom of choice and movement;
- clause 12's subsection 41(1)(a)(iv), which bans a doctor authorising up to three days of the involuntary detention of a person, unless 'adequate treatment, care or support cannot be provided in a less restrictive environment';
- clause 43's subsections 48Y(1)(i), which dictates that in making a forensic mental health order the ACAT will only impose on the subject person the minimum restrictions necessary for their safe and effective care and the protection of public safety;
- clause 43's 48ZA(2)(f), which requires the ACAT to only make a forensic psychiatric treatment order, if it is satisfied that the treatment, care or support to be provided under that order cannot be adequately provided in another way that would involve less restriction of the person's freedom of choice and movement; and
- clause 43's 48ZH(2)(g), which states that the ACAT cannot make a forensic community care order, unless it is satisfied that the treatment, care or support to be provided under it cannot be adequately provided in another way that would involve less restriction of the person's freedom of choice and movement.

These provisions explicitly reflect Principle 9(1) of the United Nations Mental Health Principles. It states: 'Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others'.

Some of the Bill's provisions that would apply to the whole Act further align it with the Convention on the Rights of People with Disabilities and the *Human Rights Act 2004*. In so doing, these provisions minimise the extent to which people's liberty, freedom of movement, and other rights provided by the *Human Rights Act 2004*, are encroached upon by the

Bill's powers of apprehension, removal, assessment, detention, restriction of movement, treatment, care and support.

These provisions are contained in clause 11's new section 6 (Principles applying to the Act).

6.3.4 Provisions that circumscribe specific powers of apprehension, removal, assessment, detention, restriction of movement, treatment, care and support

The Bill provides for a new section 36ZO and 48ZX process of advising a person twice before the chief psychiatrist and care coordinator can exercise the new section 36ZC and 36G powers, which are applicable to people contravening their psychiatric treatment orders or community care orders, respectively.

Clause 11's section 36ZC and clause 11's 36G no longer contain the powers respectively given by the current Act's:

- section 35, for apprehending and removing a person to an approved mental health facility to ensure the person receives the treatment, care and support required by their order that they are not receiving because they are contravening the order, and
- section 36ZK, for apprehending and removing a person to an approved community care facility to ensure the person receives the treatment, care and support required by their order that they are not receiving because are contravening the order.

Instead, new sections 35 and 36G rely on clause 11's section 36ZO process for a person's contravention of their order, where that contravention is not absconding from a facility.

Section 36ZO dictates that:

- the person must be given oral advice to comply with the order, andthen,
- if they continue to not comply, they must be given a written advice, andthen,
- if the person still fails to comply, they can be apprehended and removed to a facility.

Clause 119's new section 139F supplies the powers to do the

apprehension and removal, if that is what is ultimately necessary.

This process of giving oral and written advices to a person, before apprehending and removing them, extends them opportunities to choose to use their order to facilitate their recovery. Current section 35's and 36G's processes of immediately apprehending and removing, before an oral and then a written advice, gives the person no chances to make this choice, after they initially choose not to make it.

Clause 119's new section 139F powers of apprehension and removal, if that is what is ultimately necessary. These powers are significantly restrained in three main ways.

First, they may only be exercised by persons authorised and then only when they are conducting certain actions.

Second, most of these provisions, can only be exercised once ACAT has first made a mental health or forensic mental health order in respect of a person.

Third, subsection 139F(2)(c) dictates that those authorised persons enabled by subsection 13F(1) must not only 'use the minimum force necessary to apprehend the person and remove the person', but also only to remove the person to an 'approved mental health facility' or 'another place where the person may be detained for treatment, care and support'.

6.4 Powers to restrict communications and how they are reasonable and justifiable

The Bill, under clause 11's section 36ZL:

- permits the chief psychiatrist to restrict the communications of a person under a psychiatric treatment order or forensic psychiatric treatment order; and
- allows the care coordinator to restrict the communications of a person subject to a community care or forensic community care order.

These powers engage and limit the right to 'seek, receive and impart information and ideas of all kinds' provided by subsection 16(2) of the *Human Rights Act 2004*.

Further, if the restrictions are on the person's communication with 'family' members, they also engage and limit section 11 of the *Human Rights Act*

2004.

It is important to bear in mind that, as the Note to section 11 states, the meaning of 'family' in that right, is 'broad'.

These powers are reasonable and justifiable under section 28 of the *Human Rights Act 2004*, for six main reasons.

First, the limits cannot be imposed unless the orders made by ACAT state they can be.The provisions allowing ACAT to state in an order that there can be limits placed on the communications of the person who is subject to the order:

- clause 11's subsection 36W(1)(c), in the case of a psychiatric treatment order;
- clause 11's subsection 36ZE(1)(d), in the case of a community care order;
- clause 43's subsection 48ZB(1)(c), in the case of a forensic psychiatric treatment order; and
- clause 43's 48ZD(1)(d), in the case of a forensic community care order.

Second, the chief psychiatrist or care coordinator cannot impose the limits allowed by the orders unless they believe, *on reasonable grounds*, that they are *necessary for effective treatment*, as per clause 43's section 48ZO(1)(c) in the case of forensic mental health orders and clause 11's 36H(2)(b) in the case of mental health orders.[94]

Third, under clause 11's section 36ZL(6), a limit may not be imposed for more than seven days.

Fourth, clause 11's subsection 36ZL(3) prohibits the chief psychiatrist and care coordinator imposing a limit on the communications of a person who is subject to a mental health order with someone authorised under a territory law to communicate with the person. Clause 43's subsection 48ZO(3) prohibits the same in respect of a person who is subject to a forensic mental health order.

Fifth, clause 11's:

[94] In stark contrast, the restrictions imposed in *Nowicka v Poland* ((2002) European Court of Human Rights, Application No. 30218/96, 3 December) were plainly not pursuing any legitimate aim.

- subsection 36ZM(1) provides that the chief psychiatrist or the care coordinator commits a strict liability offence, if they impose a limit on communication by a person subject to a mental health order and fail to ensure that the person has reasonable access to facilities and adequate opportunity to contact the public advocate and the person's lawyer; and
- subsection 36ZM(2) provides that the chief psychiatrist or the care coordinator commit a strict liability offence, if they impose a communication limit on such a person and the public advocate or the person's lawyer asks the chief psychiatrist or the care coordinator to give any reasonable assistance necessary to access the person and the relevant official fails to ensure that that assistance is given.

Sixth, whenever they are deciding whether to impose a limit on a person's communication, or making such impositions, the chief psychiatrist and care coordinator must:

- as clause 11's section 6 requires, take into account the section 6 Principles, and
- as section 40B of the *Human Rights Act 2004* requires, do so, in a way that is compatible with the *Human Rights Act 2004*, in so far as that is consistent with the proper interpretation of the powers to impose communication limits.

6.5 Offences related to denying a person's rights to information and communications and the right of the accused to be presumed innocent

Subsection 23(1)(a) of the *Criminal Code 2002* (ACT) (the ACT Criminal Code) provides that offences which *state* that they are strict liability offences are, *ipso facto*, strict liability offences. The Bill's sections 18 and 36ZM, in clause 11, and section 48ZP, in clause 43, state that they are strict liability offences.

Subsection 23(1)(a) of the ACT Criminal Code declares that there are no fault elements for any of the physical elements of an offence, if the law creating the offence provides that it is a strict liability one. Section 14 of the Criminal Code defines these physical elements as conduct, results of conduct, or circumstances in which conduct or results of conduct occur.

This means that sections 18, 36I and 48ZP displace the common law

presumption that a person is not found guilty of an offence unless the prosecutor shows that the accused person had the requisite intent to commit the offence. Parliaments frequently displace this presumption by enacting strict liability offences, such as those in sections 18, 36ZM and 48ZP.

Sometimes, strict liability offences are regarded as contrary to the human right to be presumed innocent until proven guilty because they presume the person committed them, if they committed the acts that constitute the offences, regardless of whether the person intended to commit those acts.[95] Subsection 22(1) of the *Human Rights Act 2004* enshrines the right to be presumed innocent in the ACT statute book.

Under section 18, the owner of a mental health facility that is not conducted by the Territory commits an offence if they, without reasonable excuse, fail to comply with clause 11's sections 15 to 17, all inclusive.

Under subsection 36ZM(1), a 'relevant official' commits an offence if they:

- impose a limit on communication by a person subject to a mental health order, and
- fail to ensure that the person has reasonable access to facilities and adequate opportunity to contact the public advocate and the person's lawyer.

Further, under subsection 36ZM(2), the relevant official also commits an offence if they:

- impose a limit on communication by a person subject to a mental health order; and
- the public advocate or the person's lawyer asks them to give any reasonable assistance necessary to access the person, and
- the relevant official fails to ensure that assistance is given.

Subsections 48ZP(1) and 48ZP(2) respectively provide for similar offences in respect of persons who are subject to forensic mental health orders.

These offence provisions are considered to be proportionate and

[95] Bronnit, S. and McSherry, B. (2001) *Principles of Criminal Law*, LBC Information Services, Sydney, Australia, pp.190-191. See also *He Kaw Teh v The Queen* (1985) 157 CLR 523 at 157.

reasonable limitations on this right, as required by section 28 of the *Human Rights Act 2004*, because it is imperative the relevant official enables the person to access the two people who are statutorily bound to protect the person's interests: the public advocate under section 10(a) of the *Public Advocate Act 2005* (ACT) and the lawyer by the person's instructions and the rules provided for by Division 8.3.2 of the *Legal Profession Act 2006* (ACT).

Even if the person is not being subjected to improper or unlawful conduct, the person's ability to communicate with their lawyer or the Public Advocate allows them to obtain advice that is *independent* of the chief psychiatrist, the community care coordinator, and those people who the chief psychiatrist or community care coordinator has employed, or contracted to provide particular services.

This is so, even if the lawyer's or Public Advocate's advice to the person:

- Does not differ from what the people employed or contracted by the chief psychiatrist or community care coordinator advised the person, or would have advised the person, had the person sought their advice, and
- confirms that the treatment, care or support that the person is receiving is in accordance with the spirit and letter of relevant law, health services and community care service standards, and treatment, care and support protocols.

Articles 7 and 9 of the International Covenant on Civil and Political Rights also apply here.

The penalties for the section 18, 36ZM, and 48ZP offences also accord with the Government's policy on strict liability offences. The maximum penalty for committing the section 18 and subsection 36ZM(1) and 48ZP(1) offences is twenty penalty units. The maximum penalty for committing the subsection 36ZM(2) and 48ZP(2) offences is fifty penalty units.

6.6 Powers of entry, search and seizure and the reasonableness and justifiability of them

Clause 119's section 139F(2) entry powers and section 140 search and seizure powers engage and limit the right stated by subsection 12(a) of

the *Human Rights Act 2004* 'not to have his or her privacy, family, home or correspondence interfered with unlawfully or arbitrarily'.

The entry, search and seizure powers are considered to be justifiable undersection 28 for three main reasons.

First, these powers are highly circumscribed by sections 139F(2) and 140 clearly expressing that they can only be exercised by persons authorised by specified provisions to conduct actions enabled by those provisions and, then, only when those authorized persons are acting under those provisions.

What these provisions are, and how they highly circumscribe the power that is exercisable under subsection 139F(2), is explained under *6.3.4 Provisions that circumscribe specific powers of apprehension, removal, assessment, detention, restriction of movement, treatment, care and support*. The same explanation wholly applies to the entry powers provided by subsection 140(2), because they can only be exercised under the same provisions.

Second, subsection 139F(2) specifies that the people authorised by the above listed provisions may only use the:

- necessary and reasonable assistance and minimum force to enter any premises to apprehend, remove or take the person to a place; and
- necessary and reasonable assistance to enter premises.

The *World Health Organisation Resource Book on Mental Health, Human Rights and Legislation* (2005) expressly acknowledges that there need to be legal powers that enable:

Entering private premises, arresting a person and taking that person to a place of safety when there are reasonable grounds to suspect that person represents a danger to self or others.[96]

There is a large body of international human rights case law making clear that people should have a low expectation of privacy in spaces outside of

[96] World Health Organisation (2005) *World Health Organisation Resource Book on Mental Health, Human Rights and Legislation*, p.72 <http://www.who.int/mental_health/policy/legislation/Resource%20Book_Eng2_WEB_07%20(2).pdf>, accessed 14 January 2014.

regular private residences.[97] For example, violations of the right have even not been found where people authorised by law to do so, such as transport inspectors, have entered highly personal spaces such as the sleeping spaces of boats[98] and trucks[99].

Subsection 140(2) expressly allows searches to be conducted only if the authorised person has reasonable grounds for believing that the person is carrying 'anything that would present a danger to the authorised person or another person' or could be used to escape the authorised person's custody. Therefore, it cannot be relied on to conduct routine or random searches.

It must be noted here that:

- Under section 19A of the *Work Health and Safety Act 2011* (ACT), the employers of authorised persons have a primary duty of care to ensure so far as is reasonably practicable that the health and safety of workers and others persons is not put at risk from work carried out as part of the employer's business or undertaking.
- That the apprehended and removed person may be concealing a hazardous item can amount to a health and safety risk to the authorised person and others in their vicinity.

Whilst it is important to acknowledge and safeguard the welfare of a person subject to these search and seizure powers, the powers are also intended to protect other people who may be directly or incidentally involved. Although many everyday items are generally not characterized as dangerous, an authorised person must exercise appropriate judgment

[97] See, for example, the Supreme Court of Canada case *R. v. Suberu* (2009) SCC 33 and the New Zealand Court of Appeal decision *R. v. Grayson & Taylor* [1997] 1 NZLR 399.

[98] In Canada, a New Brunswick summary conviction appeal court held in *R. v. Kinghorne* (2003) that '[a]lthough crewmembers used a portion of the vessel to sleep and eat while at sea, 'there was no permanency of any manner and such was ancillary to the principal use of the vessel and would not convert the entire vessel into a dwelling house' (NBQB 341 para. 31).

[99] *R. v. Nolet* (2010) in which the Supreme Court of Canada recognised only a limited expectation of privacy in the sleeping cab of a commercial truck because 'the cab of a tractor-trailer rig is not only a place of rest but a place of work, and the whole of the cab is therefore vulnerable to frequent random checks in relation to highway transport matters' (SCC 24, para. 30-1, pp.43-44).

on a case by case basis to determine if an item should be seized. This is supported by the requirement of the higher standard of 'reasonable grounds to believe' that an item could be dangerous or used to assist the person to escape from custody.

In addition, subsection 140(4) requires anything seized be returned to its owner except for in limited circumstances - in many cases, seizure is a temporary measure whilst the person receives appropriate treatment and care.

Further, section 140 restricts permissible searches to frisk and ordinary search, as opposed to more intrusive strip searches or body cavity searches, which prison and customs officers are typically legally empowered to do.[100]

The powers of entry, search and seizure are all expressly provided for the purposes of apprehending and removing a person to an approved mental health facility or other places the person can be detained to receive treatment, care and support.

People reasonably expect hospitals and other places treatment, care and support to be safe.[101] Their reason for being is to be a therapeutic environment, not a potentially injurious or fatal one. Further, it is well documented that sometimes patients and staff are assaulted,[102] or

[100] See that in *R. v. Simmons* (1988) 45 C.C.C. (3d) 296 (S.C.C.), the Chief Justice of the Supreme Court of Canada, Dickson CJC, referred to section 8 of the Canadia Charter of Human Rights and Freedoms is the right to privacy and stated that different types of searches raise different issues and entirely different human rights law issues 'for it is obvious that the greater the intrusion, the greater must be the justification and the greater the degree of constitutional protection'. The Charter is embedded in Canada's Constitution. This approach was confirmed in the 1999 Supreme Court of Canada decision of *R. v. Monney* (1999) 133 C.C.C. 129.

[101] See, for example, that *R (Wilkinson) v. Responsible Medical Officer Broadmoor Hospital* [2002] WLR 419, a United Kingdom Court of Appeal case, suggests that an express power of detention includes, where necessary, a power to search. The Court found that the power to search was necessary to the hospital's primary function of treating patients and its duty to provide a safe environment for patients and staff. This part of the decision has been subsequently reapplied in a United Kingdom High Court case *R. v Home Secretary, ex parte Leech* [1994] QB 198.

[102] See, for example, State of Victoria (2005) *Occupational violence in nursing: An analysis of the phenomenon of code grey/black events in four Victorian hospitals*, February <http://www.health.vic.gov.au/__data/assets/pdf_file/0008/17585/codeblackgrey.pdf>,

patients self harm,[103] with items brought into the health facilities.

In this connection, it is important to note the (United Kingdom) House of Lords case *Savage v South Essex Partnership NHS Foundation Trust* (2008). It involved a person who completed suicide while receiving in-patient psychiatric services from the National Health Service. The Court held that:

- health authorities have an 'over-arching obligation to protect the lives of patients in their hospitals', pursuant to the right to life;
- this obligation includes a duty to ensure that the policies, procedures and systems in place at the hospital adequately safeguard life;
- if the hospital authorities have performed these obligations, casual acts of negligence by members of staff will not give rise to a breach of the right to life;[104]

6.7 Human Rights Considerations regarding Chapter 7 – Forensic mental health

As the new Forensic Mental Health Orders under Chapter 7 will apply where a person has become involved with the criminal law, impacts and limitations on human rights have been considered within this context.

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accessed 14 January 2014 and Driscoll, T. (2008) *Occupational exposure of Australian nurses*, Australian Safety and Compensation Council.

[103] Victoria (2012) *Chief Psychiatrist's investigation of inpatient deaths 2008–2010* p.28 <http://docs.health.vic.gov.au/docs/doc/76A4EC124AB13B5ECA2579A50019DE41/$FILE/cp-investigation-inpatient-deaths.pdf> accessed 12 January 2014.

[104] [2008] UKHL 74 (10 December 2008), per Lord Rodger at para. 45. As well as the 'general obligation' to protect life through proper systems, hospitals are under an 'operational obligation' to take all reasonable steps and measures to prevent the suicide of any patient that the hospital knows or ought to have known presents a 'real and immediate' risk of suicide and '[i]f they fail to do this, not only will they and the health authorities be liable in negligence, but there will also be a violation of the operational obligation under article 2 [of the European Convention on Human Rights] to protect the patient's life [para.72].' Citing jurisprudence of the European Court, the House of Lords stated that 'the authorities are under an obligation to protect the health of persons deprived of liberty. By this the Court does not mean simply an obligation to have systems in place to provide access to necessary health care, but an obligation actually to provide it [Baroness Hale at para. 98].

Chapter 7 engages, and supports, the following rights in the *Human Rights Act 2004*:

- Section 8 – Non-discrimination and equality before the law
- Section 10 – Protection from torture or cruel, inhuman or degrading treatment
- Section 19 – Humane treatment when deprived of liberty

Chapter 7 engages, and places limitations on the following rights in the *Human Rights Act 2004*:

- Section 12 – Privacy and reputation
- Section 13 – Freedom of movement
- Section 18 – Right to liberty and security of person
- Section 19 - Humane treatment when deprived of liberty

The human rights considerations also take into account the *National Statement of Principles for Forensic Mental Health 2006*, which encourages best practice approaches in forensic mental health service provision in the form of thirteen principles. These principles include: equivalence to the non-offender; safe and secure treatment; responsibilities of health, justice and correctional systems and the Judicial determination of detention and release.

6.7.1 Rights supported by chapter 7

Section 8 — Equality before the Law

The Bill supports the right to non-discrimination and equality before the law at section 8 of the *Human Rights Act 2004*. It does this by ensuring that any involuntary measures available in the Bill can only be used in circumstances of possible risk of harm to the person themself or to another person.

Section 8 provides that everyone has the right to recognition as a person before the law and the right to enjoy his or her human rights without distinction or discrimination of any kind. Furthermore, everyone is equal before the law and is entitled to the equal protection of the law without discrimination. In particular, everyone has the right to equal and effective protection against discrimination on any ground.

Section 8 incorporates general 'equality rights'; the rule of non-discrimination and principles of equality before the law, and equal protection of the law as defined by articles 2, 16 and 26 of the ICCPR.

Recognition before the law means that the law must formally acknowledge people as subjects of the law, human beings with legal rights, not objects of the law. The right to equal protection of the law prohibits discrimination in law or in practice in any field regulated by public authorities.

The right aims to protect people from discrimination of any kind in the enjoyment of rights set out in the HRA. The recognition of equality before the law is not limited to the rights protected by the *Human Rights Act 2004*.

The *Discrimination Act 1991* provides protection from discrimination for people with certain attributes including on the grounds of disability. In addition to this, Commonwealth legislation provides further protections.

Section 8 of the *Human Rights Act 2004* is a statement of the general principle of non-discrimination and equality of treatment that applies to everyone. The *Discrimination Act 1991* does not limit section 8, nor does the *Human Rights Act 2004* limit the protections of the *Discrimination Act 1991*.

Section 10 – Protection from torture or cruel, inhuman or degrading treatment

Section 10 of the *Human Rights Act 2004* 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[105].'

Section 10 is based on article 7 of the ICCPR and is consistent with article

[105] 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.

5 of the Universal Declaration of Human Rights. The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment which is also relevant to this right was developed having regard to these two articles.[106]

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[107].

The rule against torture has non-derogable status in human rights law, made clear in Article 2(2) of the UN Convention against Torture, which states; 'no exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture'.

A person being taken into custody or being detained must be treated with humanity and with respect for human dignity, and must not be subject to cruel, inhuman or degrading treatment, by anyone exercising authority under the order or implementing or enforcing the order.

Where a patient is detained under mental health laws, treatment given without consent and with the use of force on the basis of an established 'medical necessity' will not normally constitute inhuman and degrading treatment.[108]

The Bill supports this right as a stated object of the Act as proposed is to 'ensure that people with a mental disorder or mental illness receive assessment and treatment, care or support in a way that is least restrictive or intrusive to them' (see clause 11, new section 5 — Objects of Act). The application of the proposed principles also support this right in particular in relation to the principle 'that a person with a mental disorder or mental illness has the right to be able to access services that... observe, respect and promote the person's rights, liberty, dignity,

[106] *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, adopted andopened for signature, ratification and accession by General Assembly resolution 39/46 of 10 December 1984,ratified by Australia 8 August 1989.

[107] 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

[108] *R (on the application of Wilkinson) v The Responsible Medical Officer Broadmoor Hospital and Others* [2001] EWCA Civ 1545, [2002] 1 WLR 419.

autonomy and self-respect (see clause 11, new section 6 (f)(ii)).

The role of the chief psychiatrist also includes an obligation to ensure that any treatment and care that is determined for a person the subject of a forensic mental health order must not impose 'undue stress or deprivation, having regard to the benefit likely to result from the treatment, care or support' (see section 48ZC(3)).

Section 19 – Humane treatment when deprived of liberty

Section 19 of the *Human Rights Act 2004* 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 has stated that compliance with article 10 of the International Covenant on Civil and Political Rights (section 19 of the *Human Rights Act 2004*) requires that the managers of a prison ensure mental health treatment for prisoners with mental disabilities as well as humane conditions of confinement.[109]

A human rights approach to mental health treatment for prisoners recognises the importance of continuity of care to ensure that individuals have access to treatment, once released.

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 Human Rights 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.[110]

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*

[109] 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...

[110] Alexander, T, Bagaric, M & Faris, P , 2011 '*Australian Human Rights Law*', CCH Australia, page 292.

Justice and Community Safety[111] and *Enea v Italy*[112].

In discussing the right in *Eastman*, Refshauge J pointed to the European Court of Human Rights authorities as requiring that 'the State must ensure that a person is detained in conditions which are compatible with respect for his human dignity'[113]. Further, the detention should 'not subject him to 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 wellbeing are adequately secured by, amongst other things, providing him with the requisite medical assistance.[114]

3.4.3.1 Human Rights Considerations

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

- 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.
- Prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialised institutions under medical management.
- During their stay in a prison, such prisoners shall be placed under the special supervision of a medical officer.
- 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 2007* requires that detainees should receive health care equivalent to the community standard. This is

[111] [2010] ACTSC 4

[112] [2009] ECHR 74912/01

[113] Cenbauer v Croatia [2006] ECHR 73786/01; (2007) 44 EHRR 49 at 44.

[114] *Enea v Italy* [2009] ECHR 74912/01

Eastman v Chief Executive of the Department of Justice and Community Safety [2010] ACTSC 4

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 2007* 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 2004* protects the rights of detainees. Chapter 8 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

Section 10 – protection from torture and cruel, inhuman or degrading treatment

Section 10 of the *Human Rights Act 2004* 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[115].' 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[116].

Neglecting to provide needed treatment to alleviate mental suffering may violate this section, as may deliberately withholding such treatment. The prohibition should be interpreted to extend the widest possible protection against abuses, whether physical or mental[117].

[115] 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.

[116] 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

[117] Ibid.

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[118].

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 *Human Rights Act 2004* 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.

The director-general must-

- at the person's request continue the detention, treatment or care in the mental health facility; or

[118] Ibid.

- 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 patient transfer', they must either be released; allowed to remain at the facility voluntarily; or where the circumstances allow, be detained under an order under the *Mental Health (Treatment and Care) Act 1994*.

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 *Human Rights Act 2004* 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 has stated that compliance with article 10 of the ICCPR (equivalent section 19 of the *Human Rights Act 2004*) requires prison management to ensure mental health treatment for prisoners with mental disabilities as well as humane conditions of confinement.[119]

A human rights approach to mental health treatment for prisoners 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

[119] 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...

work with the appropriate agencies to determine what after-care services are necessary and can be arranged so that individuals will have necessary treatment, care, and support when they return to the community[120].

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.[121]

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*[122] and *Enea v Italy*[123].

In *Eastman*, 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 *Human rights Act 2004* '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.[124]

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[120]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.

[121] Alexander, T, Bagaric, M & Faris, P , 2011 '*Australian Human Rights Law*', CCH Australia, page 292.

[122] [2010] ACTSC 4

[123] [2009] ECHR 74912/01

[124] *Eastman v Chief Executive of the Department of Justice and Community Safety* [2010] ACTSC 4

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

The Bill proposes:

- a new class of involuntary order to be known as a forensic mental health order and associated provisions; as well as
- a new classification – 'correctional patients' - for people detained in a correctional centre who are to be transferred to a mental health facility on a voluntary basis.

The Australian Institute of Health and Welfare report *The health of Australia's prisoners 2009*, released in June 2010, outlined that:

- 38 percent of prison entrants reported having received a mental health diagnosis at some time;
- 43 percent had received a head injury resulting in a loss of consciousness, an indicator of possible brain injury, and
- 26 percent of prison entrants were referred to prison mental health services for further observation and assessment, following their initial assessment.

Although difficult to precisely measure, experience in the ACT reflects the national and international evidence of high rates of mental health problems experienced by those involved within the criminal justice system compared with the general population.

Forensic patients are jointly managed by either ACT Corrective Services or ACT Youth Justice, with *Mental Health (Treatment and Care) Act 1994*. The Public Advocate for the ACT (PA ACT) also has an important role with respect to forensic patients. In the 2012-2013 reporting period, the PA ACT provided forensic-related advocacy on 223 occasions to 62 individuals brought to the PA ACT's attention.

It is proposed that the provision for forensic patients should sit within a broad and well-defined set of principles and objects in the *Mental Health (Treatment and Care) Act 1994* with amendments proposed in the Bill.

Principles that apply to forensic orders are distinguished from those that apply to civil mental health orders by the need to protect the safety of the community.

The proposed forensic mental health orders include a criterion that the orders would be made where the nature of the person's behaviour or risk to the community is serious.

Seriousness of risk to the community in this context has not been defined, but will be considered in the assessment and hearing process according to individual circumstances. This is because it is considered that defining the term has the potential to disadvantage an individual in some circumstances and in other circumstances to exclude from consideration people who pose a serious risk.

The courts are responsible for determining whether or not an accused is fit to plead, or not guilty by reason of mental impairment and for making orders placing an accused person under the jurisdiction of the ACAT.

While the current *Mental Health (Treatment and Care) Act 1994* provides for the ACAT to make civil mental health orders where an accused person has been referred by a court, there remains concern that in a number of respects, existing arrangements may fail to adequately address community safety concerns.

This concern relates to the reliance upon administrative rather than legislative safeguards to ensure forensic patients are not released from mental health care inappropriately. It is intended that the creation of a forensic mental health order will address this and other inadequacies in current legislative arrangements.

The Bill also proposed amendments to provide for the transfer of people detained in a correctional centre to an approved mental health facility. This scheme will apply to a person with a mental illness who requires inpatient mental health treatment and who consents to such treatment.

The correctional patient provisions, at new Chapter 8, propose to:

- monitor and control the transfer of voluntary mental health patients between correction 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 an interstate Recognition of Orders Scheme.

6.7.2 Rights engaged and limited by chapter 7

The limits upon human rights in chapter 7 listed above are reasonable and justifiable in a free and democratic society for the purposes of section 28 of the *Human Rights Act 2004* having regard to the factors set out below.

Human rights are subject to only reasonable limits which are demonstrably justifiable. Human rights may only be limited when the following relevant factors are considered:

- the nature of the right affected;
- the importance of the purpose of the limitation;
- the nature and extent of the limitation;
- the relationship between the limitations and its purpose, and
- the least restrictive means reasonably available to achieve the purpose the limitation seeks to achieve.[125]

In ensuring that limitations upon individual human rights are demonstrably justifiable, public authorities must act consistently within these rights. In making decisions, public authorities must give proper consideration to relevant human rights.[126]

Mental Health legislation requires 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 state has an obligation to protect a person from harm that can result from a mental illness or mental disorder. Furthermore, the community has a legitimate expectation that it will be protected from a serious risk of harm.

The proposed forensic mental health orders, by their nature, limit the subject person's liberty and their freedom of movement, to the extent

[125] Section 28 of the *Human Rights Act* 2004.

[126] Section 40B of the *Human Rights Act* 2004.

that it serves to ensure their safety, and treatment and care, while also ensuring the safety of members of the community from the risk of serious harm.

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.[127] 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.[128]

In the context of the Bill, these positive obligations will apply to both a person who becomes subject to an order because they are being protected from harm[129] and to the community generally.

The objects and principles as amended by the Bill contained in chapter 2 also apply to the forensic mental health provisions. These objects and important concepts provide important guidance for decision makers. The application of these concepts to forensic mental health provisions is the key rationale for including forensic provisions in the *Mental Health (Treatment and Care) Act 1994* rather than as a separate enactment.

The application of the objects and important concepts serves to ensure that the general application of provisions that can significantly limit a person's human rights can only operate to the extent that the person's treatment and care demands.

The leading European case on a person's human rights when detained or

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

[128] Ibid, p.425.

[129] *Rabone v Pennice Care NHS Trust* [2012] UKSC 2. In this case the court found that the NHS Trust operational duty under article 2 of the *European Convention for the Protection of Human Rights and Fundamental Freedoms* was engaged in the case of a mental health patient.

confined in mental health care is Winterwerp v the Netherlands130. The confinement of a person with a mental illness must comply with the requirements laid down in Winterwerp, namely that detention or confinement:

- must have been reliably established, through objective medical expertise, that the patient has a true mental disorder;
- the mental disorder must be of a kind or degree warranting compulsory confinement, andthat
- the validity of continued confinement depends upon the persistence of such a disorder.

Chapter 7 satisfies each of these requirements and together with other protections and safeguards, it can be said that the limitations on rights in the forensic mental health orders scheme in the Bill are reasonable and 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.

Chapter 7 sets out in detail the matters the ACAT must take into consideration or be satisfied of, including that:

- the person must have had some involvement with the criminal justice system.
- the person is charged and the charge is subsequently dismissed and the person is referred to the ACAT (under section 334 (2) (a) of the *Crimes Act 1900 (ACT)*),
- the person is remanded by a court in relation to an ongoing criminal charge;
- the person's case is still being considered by the court and has been

[130] 6301/73 (1979) ECHR 4.

found either temporarily or permanently unfit to plead;

- the 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;
- the person is serving a custodial or community based sentence.
- the person must have a mental illness;
- the person must pose a substantial risk to their own health or safety or be doing or be likely to do serious harm to others;
- because of the mental disorder or mental illness, the person has seriously endangered, is seriously endangering, or is likely to seriously endanger, public safety, and
- psychiatric treatment or the community care is likely to reduce the deterioration of the person's mental health or the endangerment to the community.

Other significant human rights which are engaged in Chapter 7 include the freedom of movement, freedom of expression, privacy and reputation, the right to liberty and the security of persons. These human rights restrictions are justifiable, in light of the purpose of the provisions within Chapter 7 of the Bill, which include ensuring the safety of the members of the community from the risk of serious harm, to identify and provide treatment, care and support for people subject to criminal proceedings who present with a mental illness or mental disorder.

These safeguards seek to promote the least restrictive treatment and care for those requiring treatment and care, and to ensure that the new scheme provides for relevant information to be shared with people affected by the person's conduct.

It is also important to consider the role of forensic mental health orders in the context of the prison environment.

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

- 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.

- Prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialised institutions under medical management.
- During their stay in a prison, such prisoners shall be placed under the special supervision of a medical officer.
- 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 2007* 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 2007* 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.

Section 12- Privacy and reputation

Section 12 of the *Human Rights Act 2004* provides that everyone has the right not to have his or her privacy, family, home or correspondence interfered with unlawfully or arbitrarily and not to have his or her reputation unlawfully attacked.

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).[131]

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 and reputation. The comment notes that the term 'unlawful' means that

[131] Lester QC., Pannick QC (General editors), 2005, *Human Rights Law and Practice'*, Second edition,

LexisNexis UK, p.261.

no interference can take place except in cases envisaged by the law.[132]

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 ICCPR and should be reasonable in the particular circumstances.[133]

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).

There are a number of provisions in the Bill that engage the section 12 rights including those that allow:

- certain officers to apprehend a person and take them to a mental health facility for assessment of whether the person requires immediate treatment and care;
- mental health orders and forensic mental health orders that allow a person's circumstances to be considered in detail to determine whether they require involuntary treatment, care and support;
- measures in chapter 7 that allow an affected person to be given information about a person subject to a forensic mental health order.

The shared purpose of these clauses and the new sections provided by the Bill is to protect the health and wellbeing of people with a mental illness and/or mental disorder where there is a risk posed to themselves because of that condition. This purpose upholds the right to liberty and security of person at section 18 of the *Human Rights Act 2004* by putting in place measures to minimise the risk of harms to the community by people subject to orders.

There are also provisions that support the right to privacy and reputation.

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[132] 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)

[133] Ibid, para 4.

These provisions are:

Section 13 - Freedom of Movement

The nature of the right affected (section 28 (2) (a))

The right to freedom of movement is connected to the right to liberty which is discussed further below. *Section 13* of the *Human Rights Act 2004* states: 'Everyone has the right to move freely within the ACT and to enter and leave it, and the freedom to choose his or her residence in the ACT.' A person's freedom of movement goes beyond this stated provision.

The objective of the freedom of movement was explained by Bell J in *Kracke v Mental Health Review Board*[134] in the following terms: 'freedom of movement is not just being able to move freely. As the Human Rights Committee has said in their General Comment 27, [709]; it 'is an indispensable condition for the free development of a person'. It is therefore indispensable for the development of society.

As the Committee explains, limitations on the right to freedom of movement must, under Article 12(3) of the ICCPR[135], be for permissible purposes, necessary and proportionate. Article 12(3) indicates that it is not sufficient that the restrictions serve the permissible purpose; they must also be necessary to protect them. Restrictive measures must conform to the principles of proportionality, and must be the least intrusive instrument amongst those which might achieve the desired results.

Laws that expressly limit the movement of individuals must be applied less expansively, requiring a higher threshold of proof that an individual constitutes a risk before their freedom is restricted.

The importance of the purpose of the limitation is directly related to the concerns for the wellbeing of the person and/or the community arising from the person's mental illness and/or mental disorder. The power of the ACAT or the relevant official to restrict a person's freedom of

[134] & Ors (General) [2009] VCAT 646 (23 April 2009).

[135] Article 12(3) o ft he ICCPR states: The above-mentioned rights shall not be subject to any restrictions except those which are provided by law, are necessary to protect national security, public order, public health or morals or the rights and freedoms of others, and are consistent with the other rights recognized in the present Covenant. http://www.un-documents.net/iccpr.htm

movement is the minimum necessary to provide for the person's treatment, care and support. In some cases, for instance where a person is to be detained in an approved mental health facility and subjected to involuntary seclusion, the person's freedom of movement is significantly limited. This limitation must not be arbitrary as any decision to use these measures must consider the person needs in the context of their mental state, the risks to the person or someone else and the availability of less restrictive alternatives.

Section 18 – Right to liberty and security of the person

Section 18 of the *Human Rights Act 2004* provides the right to liberty of person; in particular, no one may be arbitrarily arrested or detained.

International human rights judicial institutions have held that prohibition of arbitrary deprivation of liberty goes further than the prohibition of unlawful deprivations, as arbitrariness is a principle above, rather than within the law. In *Van Alphen v The Netherlands*[136], the UN Human Rights Committee, in interpreting Article 9(1) of the ICCPR[137], held that: ''arbitrariness is not to be equated with 'against the law', but must be interpreted more broadly to include elements of inappropriateness, injustice and lack of predictability'. In the Committee's opinion: 'remand in custody pursuant to lawful arrest must not only be lawful but reasonable in all the circumstances. Further, remand in custody must be necessary in all the circumstances, for example, to prevent flight, interference with evidence or the recurrence of crime.'

The right to security and liberty of person is engaged and limited as detention in an approved mental health facility or an approved community care facility could amount to arbitrary detention (section 18(1) of the *Human Rights Act 2004*).

The limitation on the right to liberty and security of person exists to allow the ACAT or the relevant official to impose requirement consistent with the need to treat and care for the person's mental illness and/or disorder.

[136] No 305/1988 UN Doc CCPR/C/39/D/305/1988 (1990).

[137] Article 9(1) of the ICCPR states: Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law. http://www.un-documents.net/iccpr.htm

Where a mental health order or forensic mental health order is made by the ACAT the person may be treated, cared for and supported involuntarily, potentially while detained in a facility. The provisions of the Bill also allow a person to be detained in a number of circumstances including where the criteria for emergency detention are met and where a person the subject of an order absconds from a facility.

The limitation on the right to liberty and security of person are necessary to ensure the person or another person does not suffer harms as a result person's mental illness and/or disorder. Forensic mental health orders also allow for the risk of public endangerment to be addressed.

The measures in the Bill that limit this right are the least restrictive approach available in the circumstances. Measures allowing for detention in approved mental health facilities or approved community care facilities are only to be used when no other less restrictive measures are available to achieve the aims of treatment and care. These measures are necessary to achieve the purpose of providing for the treatment and care of people with a mental illness and/or mental disorder. It is also relevant that a stated aim of treatment and care can include the protection of someone else or in the case of forensic mental health order a risk of public endangerment.

The Bill requires the relevant official to advise the ACAT in writing where they come to the view that the person is no longer someone for whom the ACAT could make an order. Furthermore, the Bill includes the ability for a person to seek review of an order or part of an order.

6.8 Human Rights Considerations regarding *Chapter 8 - Correctional Patients*

As Chapter 8 will apply alongside existing corrections principles, impacts and limitations on human rights are considered specifically in this context. The United Nations *Standard Minimum Rules for the Treatment of Prisoners* provides the following protection for people with mental illness in correctional facilities:

- 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.

- Prisoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialised institutions under medical management.

- During their stay in a prison, such prisoners shall be placed under the special supervision of a medical officer.

- 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 2007* 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 2007* 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 2004* protects the rights of detainees. Chapter 8 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

Section 10 – protection from torture and cruel, inhuman or degrading treatment

Section 10 of the *Human Rights Act 2004* 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[138].' 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[139].

Neglecting to provide needed treatment to alleviate mental suffering may violate this section, as may deliberately withholding such treatment. The prohibition should be interpreted to extend the widest possible protection against abuses, whether physical or mental[140].

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[141].

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 *Human Rights Act 2004* 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

[138] 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.

[139] 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

[140] Ibid.

[141] Ibid.

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.

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 patient transfer', they must either be released; allowed to remain at the facility voluntarily; or where the circumstances allow, be detained under an order under the *Mental Health (Treatment and Care) Act 1994*.

These provisions ensure the continuity of care to individuals that have a mental illness to 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 *Human Rights Act 2004* 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 has stated that compliance with article 10 of the ICCPR (equivalent section 19 of the *Human Rights Act 2004*) requires prison management to ensure mental health treatment for prisoners with mental disabilities as well as humane conditions of confinement.[142]

A human rights approach to mental health treatment for prisoners 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 arranged so that individuals will have necessary treatment, care, and support when they return to the community[143].

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

[142] 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...

[143]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.

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.[144]

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*[145] and *Enea v Italy*[146].

In *Eastman*, 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 *Human Rights Act 2004* '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.'[147]

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

The Bill proposes:

- a new class of involuntary order to be known as a forensic mental health order and associated provisions; as well as
- a new classification – 'correctional patients' - for people detained in a correctional centre who are to be transferred to a mental health facility on a voluntary basis.

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[144] Alexander, T, Bagaric, M & Faris, P , 2011 '*Australian Human Rights Law*', CCH Australia, page 292.

[145] [2010] ACTSC 4

[146] [2009] ECHR 74912/01

[147] *Eastman v Chief Executive of the Department of Justice and Community Safety* [2010] ACTSC 4

The Australian Institute of Health and Welfare report *The health of Australia's prisoners 2009*, released in June 2010, outlined that:

- 38 percent of prison entrants reported having received a mental health diagnosis at some time;
- 43 percent had received a head injury resulting in a loss of consciousness, an indicator of possible brain injury, and
- 26 percent of prison entrants were referred to prison mental health services for further observation and assessment, following their initial assessment.

Although difficult to precisely measure, experience in the ACT reflects the national and international evidence of high rates of mental health problems experienced by those involved within the criminal justice system compared with the general population.

Forensic patients are jointly managed by either ACT Corrective Services or ACT Youth Justice, with *Mental Health (Treatment and Care) Act 1994*. The Public Advocate for the ACT (PA ACT) also has an important role with respect to forensic patients. In the 2012-2013 reporting period, the PA ACT provided forensic-related advocacy on 223 occasions to 62 individuals brought to the PA ACT's attention.

It is proposed that the provision for forensic patients should sit within a broad and well-defined set of principles and objects in the *Mental Health (Treatment and Care) Act 1994* with amendments proposed in the Bill.

Principles that apply to forensic orders are distinguished from those that apply to civil mental health orders by the need to protect the safety of the community.

The proposed forensic mental health orders include a criterion that the orders would be made where the nature of the person's behaviour or risk to the community is serious.

Seriousness of risk to the community in this context has not been defined, but will be considered in the assessment and hearing process according to individual circumstances. This is because it is considered that defining

the term has the potential to disadvantage an individual in some circumstances and in other circumstances to exclude from consideration people who pose a serious risk.

The courts are responsible for determining whether or not an accused is fit to plead, or not guilty by reason of mental impairment and for making orders placing an accused person under the jurisdiction of the ACAT.

While the current *Mental Health (Treatment and Care) Act 1994* provides for the ACAT to make civil mental health orders where an accused person has been referred by a court, there remains concern that in a number of respects, existing arrangements may fail to adequately address community safety concerns.

This concern relates to the reliance upon administrative rather than legislative safeguards to ensure forensic patients are not released from mental health care inappropriately. It is intended that the creation of a forensic mental health order will address this and other inadequacies in current legislative arrangements.

The Bill also proposed amendments to provide for the transfer of people detained in a correctional centre to an approved mental health facility. This scheme will apply to a person with a mental illness who requires inpatient mental health treatment and who consents to such treatment.

The correctional patient provisions, at new Chapter 8, propose to:

- monitor and control the transfer of voluntary mental health patients between correction 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 an interstate Recognition of Orders Scheme.

7. What do each of the Bill clauses provide?

Clause 1 Name of Act

Clause 1 says that this Act, once the Bill is enacted, is the *Mental Health (Treatment and Care) Amendment Act 2014*.

Clause 2 Commencement

Clause 2 provides that the Act will commence on a day fixed by written notice by the Minister. As is provided by subsection 77(1) of the *Legislation Act 2001*, the Minister may provide a single day or time for the commencement of the whole Act or different days and times for the commencement of different provisions.

Clause 2 also provides that if the Act has not commenced within twelve months beginning on its notification day, it automatically commences on the first day after that period.

It also clarifies that this is to remove the application of section 79 of the *Legislation Act 2001* from this Act. Section 79 states that if the Act has not commenced within six months beginning on its notification day, it automatically commences on the first day after that period.

Clause 3 Legislation Amended

This clause states that the Act will amend the *Mental Health (Treatment and Care) Act 1994*. As is flagged in the Note under the clause, the Act also amends other legislation. These consequential amendments are provided in Schedule 1 of the Bill.

Clause 4 Long Title

Clause 4 changes the current long title of the Act to this new one, 'An Act to provide for the treatment, care, support, rehabilitation and protection of people with a mental disorder or mental illness and the promotion of mental health and wellbeing, and for other purposes.'

Clause 5 Part 1 heading

The words 'Part 1' in the current Act are replaced with 'Chapter 1'.

Clause 6 Section 1

Section 1 of the Act is replaced to state that 'This Act is the *Mental Health (Treatment and Care) Act 1994*', rather than it stating that the Act 'may be cited as' that Act name.

Clauses 7 – 10 Offences against Act – application of Criminal Code etc Section 4A, note 1

These clauses makes an insertion into Note 1 of the current Act's section 4A. Note 1 lists the offences in the Act to which Chapter 2 of the Criminal Code applies.

The insertion adds four offences.

One is section 18 (failure of owner to comply with pt 3.1), a new offence described below, under clause 11's section 18, and above, under *6.5 Offences related to denying a person's rights to information and communications and the right of the accused to be presumed innocent*.

Sections 36ZM and 48ZP have new offences relating to limits on communication and section 42 has a new offence related to notification of certain people about detention.

An omission of the word 'offence' is corrected in respect of section 45.

Clause 11 Sections 5, 6 and parts 2 and 4

Sections 5, 6 and parts 2 and 4 are replaced with the following sections and chapter headings and part headings.

Chapter 2 Objects and important concepts is a new heading in the Act.

Section 5 Objects of Act provides seven objects of the Act that replace the Act's section '7 Objectives of Act'.

Just as the Objectives do, the new Objects will guide people interpreting the Act about the Act's purposes. As is clearly explained in the High Court of Australia case *Carr v The State of Western Australia* [2007][148], the objects of a statute can be used to resolve uncertainty and ambiguity in the interpretation of the statute.

For more on section 5, see the explanation of the Objects under *3.1.1 Objects and principles expressly referring to 'recovery'*.

Section 6 Principles applying to Act provides for nine Principles that are new to the Act. The Act has not previously contained Principles, *per se*.

Subsections 6(a) to 6(i), inclusive, each provides for a 'right' of a 'person with a mental disorder or mental illness', and subsection 6(j) provides for

[148] HCA 47 (23 October 2007), as per Chief Justice Glesson, at para. 5 and 7.

thirteen actions that services provided to a person with a mental disorder or mental illness 'should' do.

As the amendment states, these Principles 'must be taken into account' in 'exercising a function under this Act'. Accordingly, like the Objects in section 5, the Principles are critical to fulfilling the overall objective of statutory interpretation, which is to give effect to the purpose of the parliament – in this case, the ACT Legislative Assembly – as expressed in the text of the statutory provisions.[149]

For some more on this section, see the explanation of them under *3.1.1 Objects and principles expressly referring to 'recovery'*.

Section 7 Meaning of decision-making capacity provides for a definition that is new to the Act and central to the interpretation of many of the Bill's provisions, as is explained above under *3.1.3 Decision-making capacity provisions.*

Section 7 provides for seven elements that, altogether, amount to what constitutes a person having 'decision-making capacity' for the purposes of this Act, unless it expressly provides otherwise. A person can be said to have decision making capacity if they satisfy the 7 elements. It is the intention of the Bill that a person may *also* be said to have decision making capacity if they can satisfy the seven elements *with assistance.* That is, a person cannot be said to lack decision making capacity because they require help to demonstrate one of the elements of decision making capacity included in section 7.

Section 8 Principles of decision-making capacity outlines new principles that elaborate on whether a person does have 'decision-making capacity' as defined by section 7 of the Act.

Subsection 8(1) states six principles that 'must be taken into account' in considering a person's 'decision-making capacity' under the Act.

Subsection 8(2) stipulates that a 'person's decision-making capacity must always be taken into account in deciding treatment, care or support, unless this Act expressly provides otherwise'.

[149] That this is the overall objective of statutory construction is clearly expressed in *Project Blue Sky Inc v AMA* (1998) 194 CLR 355 at paragraph 69, among other authoritative precedents.

Subsection 8(3) mandates that an act done, or decision made, under the Act for someone who 'does not have decision-making capacity' must be done or made 'in the person's best interests.'

In this way, the Act states that any act or decision for any person with no decision-making capacity must be questioned for whether it is in the person's best interests and if it is not, another act must be done or decision made, that is.

Section 9 Meaning of *mental disorder* supplies the definition of 'mental disorder'. It wholly preserves the current Act's definition of 'mental dysfunction', but replaces 'mental dysfunction' with 'mental disorder', andspecifically excludes mental illness.

Section 9 places the definition of 'mental disorder' at the beginning of the Act, whereas 'mental dysfunction' is defined in the current Act's Dictionary at the end of the Act.

Throughout the Bill, all mentions of 'mental dysfunction' are replaced with 'mental disorder'.

Section 10 Meaning of *mental illness* adds a sixth symptom, namely 'serious disorders of streams of thought', to the Act's current definition of 'mental illness' and clarifies that the definition of mental illness includes 'sustained or repeated irrational behaviour that may be taken to indicate the presence of at least 1 of the symptoms mentioned'.

The definition of 'mental illness' is now placed at the beginning of the Act, whereas the current Act's definition of 'mental illness' is at the end of the Act in its Dictionary.

Section 11 People not to be regarded as having mental disorder or mental illness provides that a person is not to be regarded as having a 'mental illness' or a 'mental disorder', only because they may be said to be a person mentioned in one or more of the provisions of the section.

The section makes it clear that participating in behaviour or activities that may generally be thought of as immoral or unwise or unsafe or contrary to cultural norms does not in itself constitute evidence of mental illness or disorder.

Section 12 Meaning of *carer* inserts into the Act a definition of 'carer'. The current Act contains no such definition.

Section 12 makes it clear that a carer is a person who gives 'personal care, support or assistance to a person who has a mental disorder or mental illness' but excludes a person who is only providing services under a 'commercial', or 'substantially commercial', arrangement, or in the course of 'voluntary work for a charitable, welfare or community organisation' or 'education or training'.

Further, subsection 9C(2)(b) prevents a person being considered a carer, just because they are the 'domestic partner, parent, child or other relative, or guardian' of the person with a mental illness or disorder; or because they reside together.

Section 13 Proceedings relating to children inserts a new provision into the Act. It mandates that a person who is the subject of a proceeding is a child for that proceeding, if they were a child when the proceeding commenced.

Section 13 substitutes the current Act's section 6. Section 6 provides only that when it is being determined whether a person is a child for that proceeding 'regard shall be had' to the fact that a person was a child at the beginning of a proceeding.

The Dictionary of the amended Act defines 'proceeding' as an application to the ACAT, or another proceeding in the ACAT. This definition of proceeding is the same as the one in the current Act's Dictionary.

'Child', in section 13, means an 'individual who is under 18 years old', as per the Dictionary of the *Legislation Act 2001*.

Chapter 3 Rights of people with mental disorder or mental illness is an amended heading in the Act and is moved from Part 6 of the Act to the front of the Act to strengthen the focus of the Act on the experience of the person with mental illness or mental disorder and on their engagement with the mental health system.

Part 3.1 Rights in relation to information and communication is a new heading in the Act.

Sections 14 to 18 replace sections 49 to 53 of the current Act.

The proposed amendments to the sections modernise the language, require persons in charge of facilities to provide information as soon as practicable and in a form that is most appropriate to the person.

It is a new requirement that the information about the person's rights be provided to a nominated person, guardian, attorney or health attorney as well as the person and new services are inserted at the list of offices whose information must be made available at a facility.

While in the current Act it is an offence for an owner of a mental health facility that is not conducted by the Territory to fail to comply, without reasonable excuse, with the equivalent provisions as those that are provided for in Part 3.1 of the Bill, section 18 of the Bill now provides that failure to comply is a strict liability offence.

That is, section 18 states that the private owner has committed a strict liability offence if they, without reasonable excuse, fail to comply with clause 11's sections 15 to 17, all inclusive.

Under subsection 15(1), the owner must ensure that, as soon as practicable, after it is decided that a person is to receive treatment care or support at the facility, the person is, among other things:

- orally advised of their rights under the *Mental Health (Treatment and Care) Act 1994*; and
- given written information that must contain certain statements including, among other things, their rights to obtain a second medical opinion from an appropriate mental health professional, to obtain legal advice, to make an advance consent direction and to enter into an advance agreement.

Subsection 15(3) requires the owner or a mental health professional to ensure that this information is provided in a way that is most appropriate for communicating with the person. Subsection 15(4) requires that they tell the public advocate, if the person appears to be unable to understand the information.

Subsection 15(5) imposes obligations on the owner to give certain information about the person's rights to certain people, including, but not limited to, their nominated person, if they have one.

Subsection 16(1) similarly requires the owner to ensure certain information is in a place at the facility that is readily accessible to persons admitted to, or receiving treatment, care or support at, the facility. The information items that must be accessible, under this section, include, but

are not limited to:

- copies of the *Mental Health (Treatment and Care) Act 1994*, the *Guardianship Act 1991*, any other relevant legislation, and any guidance on any of that legislation produced by ACT Government Directorates;
- copies in different languages of the information containing the statements required by subsection 15(1); and
- the respective addresses and telephone numbers of ACAT, the health services commissioner, and translating, interpreting and teletypewriter services.

Subsection 16(2) mandates that the owner will prominently display, at the facility, a notice indicating the location of this information.

Section 17 compels the owner to do certain actions to enable the in-bound and outbound communications of a person who is admitted to, or receives treatment, care or support at, the facility.

Part 3.2 Nominated people is a new heading in the Act. Part 3.2 is comprised of sections 19 to 23, inclusive of all. These sections are altogether new to the Act. There are no equivalent, or approximately equivalent, provisions in the current Act.

Section 19 Nominated person sets out the requirements for nominating a nominated person and an alternate nominated person.

Subsection 19(1) enables a person with mental illness/es and/or disorder/s and decision-making capacity to nominate, in writing, that another person is their 'nominated person' and that yet another is their 'alternate nominated person'.

As is provided by Notes 1 and 2, respectively, on subsection 19(2):

- any form approved under s 146A for this provision must be used.
- under section 26, a person who makes an advance agreement under part 3.3 of the Act may set out in it the contacts details of a nominated person.

Subsection 19(2) stipulates that a person cannot be a 'nominated person' or 'alternate nominated person' unless they meet four conditions. These are that they are an adult; they agree to the nomination; they are 'readily

available', andthey are able to undertake the functions of a nominated person.

The Dictionary of the *Legislation Act 2001* provides that in all ACT legislation, 'adult' means an individual who is at least eighteen years old. The functions of a nominated person are declared by section 9F.

Section 20 Nominated person—functions specifies at:

- subsection (1) that the 'main function' of a nominated person is to ensure that the interests of the person who nominated them are respected if and when that nominator requires treatment, care or support for a mental disorder or illness; and
- subsection (2) that the nominated person has three more kinds of functions, which are receiving information under the Act, being consulted about decisions regarding the nominating person's treatment, care or support, and such other functions that the Act endows on the nominated person.

Section 21 Nominated person—obligations of person in charge makes four requirements of a person in charge of an approved mental health facility or community care facility in respect of people receiving treatment, care or support at the facility.

These requirements are to 'take all reasonable steps' to:

- ask the person receiving treatment, care or support whether they have a nominated person;
- ensure that details and the written nomination of the nominated person, are kept with the person's records;
- ensure that the currency of the nomination and nominated person's details are checked periodically, and
- ensure that the ACAT is given the nominated person's name and contact information, if the ACAT is involved in decisions about the person.

Section 22 Nominated person—end of nomination provides how a nomination ends and any obligations activated by the ending of a nomination.

The nomination ends in three ways. They are that:

- the person who made the nomination has decision-making capacity and tells a member of their treating team, orally or in writing, that they do not want the nominated person to perform the functions of a nominated person for them anymore;
- the nominated person tells a member of the person's treating team, orally or in writing, that they are unable to perform the functions of a nominated person; and
- the chief psychiatrist decides on reasonable grounds that the nominated person is unable to perform the functions of a nominated person, and gives written notice stating that the nomination has ceased to both the person who made the nomination and the nominated person, under subsection.

The member of the person's treating team who is told about a nomination ending is obliged to ensure that:

- as soon as practicable, information about the end of the nomination is entered in the person's record;
- the person is told that the information has been entered in their record, and
- the person is given a copy of the information entered in their record.

If the chief psychiatrist ends a nominated person's nomination the chief psychiatrist must advise the person who made the nomination, the nominated person and a member of the person's treating team that the nomination has ceased and make a record about their reasons for doing so. They must advise the person about advocacy services and, if the person has decision making capacity, ask if there is another person they wish to nominate.

Section 23 Nominated person—protection from liability protects a nominated person from civil liability in two ways.

Subsection 23(1) precludes them from being found civilly liable for anything they do or omit honestly and without recklessness in exercising, or in the reasonable belief that they are exercising, a function under the Act. Subsection 23(2) provides that the Territory carries any and all civil liability that may remain after the application of subsection 23(1).

For more on Part 3.2's provisions, see *3.1.3.3 Nominated persons,*

advance agreements, and advance consent directions, an earlier section of this Explanatory Statement.

Part 3.3 Advance agreements and advance consent directions is a new heading in the Act.

Section 24 Definitions—pt 3.3 supplies the Act with definitions for the new Part 3.3. They are:

representative is the treating team member nominated by the team to exercise the functions of a representative.

treating team means the mental health professionals involved in treatment, care or support of the person for a particular episode of treatment, care or support and includes any other mental health professional that the person names as their current mental health professional or who referred the person to the treating team for that particular episode of treatment, care or support..

Section 25 Rights in relation to advance agreements and advance consent directions imposes obligations on the representative of a treating team.

These obligations are in respect of the person with the mental illness or disorder. They are that the representative is required to ensure that, as soon as practicable, the person is:

- told that that they may enter into an advance agreement and/or an advance consent direction,; and
- given the opportunity to enter into an advance agreement and/or advance consent direction; and
- told that they may have someone with them to assist in creating an advance agreement or consent direction.

Section 26 Entering into advance agreement provides for how an advance agreement may be entered into and what it may contain.

A person with a mental illness or disorder who has decision-making capacity may enter into an advance agreement with their treating team. The person may address their preferences with respect to practical help they need as a result of their mental illness or disorder and any other matters the person wishes to inform their treating team about in the

advance agreement.

An advance agreement may also include a copy of an advance consent and the contact details of: the person's nominated person; the person who is likely to provide practical help; the primary carer; the guardian under the *Guardianship Act* and the attorney under the *Powers of Attorney Act 2006,* and any other relevant details.

Advance agreements are intended to be respected wherever possible. If it is not possible to respect a provision of an advance agreement, the mental health professional must make a record of the reasons why it is not on the person's medical record. Where a person wishes their preference to be binding they should include it in their advance consent direction instead.

Advance agreements are required to be:

- in writing;
- be signed by the person, the representative of the person's treating team, and the nominated person, if the person has one;
- signed by a person who is likely to provide practical help under the agreement; and
- entered in the person's record and a copy of it given to the person, the nominated person, if the person has one, and any member of the person's treating team who does not have access to the person's record.

As is indicated in the Note on subsection 26(3), any form approved under s 146A for this provision must be used.

Section 27 Making advance consent direction provides for who may make such directions, what they may and must set out, and the obligations of the representative of the treating team in respect of an advance consent direction. It does so in five subsections.

An advance consent direction may only be made by an adult with decision-making capacity who has consulted with their treating team about their options for treatment, care and support. It is a binding document and may only be overridden with the approval of the ACAT and in limited circumstances.

An advance consent direction may set out:

- what the person gives consent to by way of their treatment, care or support, including the use of particular medications or procedures, if they do not have decision-making due to a mental illness or disorder;
- does not want by way of this treatment, care or support, including the use of particular medications or procedures, if they do not have decision-making due to a mental illness or disorder; and
- the people who may be provided, and the people who are not to be provided, information on the treatment, care and support the person requires for a mental illness or disorder.

An advance Consent direction must be:

- written;
- signed by the person making the direction in the presence of a witness who is not a treating health professional for the person;
- signed by the representative of the person's treating team in the presence of a witness who is not a treating health professional for the person, and
- signed by the witness in the presence of the person making the direction and the representative of the treating team.

As is indicated in the Note on subsection 27(3), any form approved under s 146A for this provision must be used.

An advance consent direction may include the person's advance consent to electroconvulsive therapy. Where it does so, additional signatures are needed. An advance consent direction including consent to ECT must be:

- written;
- signed by the person making the direction in the presence of *two* witnesses who are not treating health professionals for the person;
- signed by the representative of the person's treating team in the presence of *two* witnesses who are not treating health professionals for the person, and
- signed by each witness in the presence of the other witness, the person making the direction and the representative of the treating team.

As is indicated in the Note on subsection 27(4), any form approved under s 146A for this provision must be used.

The representative of the person's treating team must ensure that the advance consent direction is entered in the person's record and give a copy of the advance consent direction to: the person; the nominated person, if the person has one; the guardian, if the person has one, under the *Guardianship Act*; the attorney, if the person has one, under the *Powers of Attorney Act* 2006, and any member of the person's treating team who does not have access to the person's record.

Section 28 Giving treatment etc under advance agreement or advance consent direction lays down the rules for what a mental health professional must do and may not do under such an agreement or direction.

Under the new provisions a mental health professional must 'take reasonable steps', to discover whether a person has an advance agreement and advance consent direction before giving a person treatment care or support.

Further, in the event that a person with an *advance agreement* does not have decision-making capacity, the professional will:

- if reasonably practicable, give treatment, care or support to the person in accordance with their preferences as expressed in the agreement, and
- not apprehend, detain, restrain or use force to implement the agreement.

In the event a person has made an *advance consent direction* and does not have decision-making capacity, a professional:

- may give the person treatment, care or support; or a , if the direction gives consent for it;
- particular medication or procedure;
- must not give a particular medication or procedure, if the direction indicates that the person does not consent to it, and
- must not apprehend, detain, restrain or use force to implement the direction.

The provisions allow that if a professional believes on reasonable grounds that it would be is unsafe or inappropriate to give treatment, care or support to a person without decision-making capacity in accordance with their advance consent direction and proposes to provide alternative treatment, care or support to the person, they may do so with the consent of the person's guardian or health attorney appointed under the *Guardianship Act,* or attorney under the *Powers of Attorney Act 2006, if the person is willing to accept the alternative treatment, care or support that is proposed.*

In such a case, the professional must record in the person's record the reasons why the treatment, care or support consented to in the person's advance consent direction is unsafe and why the proposed alternative treatment, care or support is to be given.

An advance agreement and advance consent direction do not provide a mental health professional with authority to compel the person to accept the treatment, care or support to which they have agreed in either document. Nor can a professional, without reference to ACAT, compel a person to accept alternative treatment where the professional believes the treatment consented to in an advance consent direction is unsafe. In both these circumstances, the power to give consent by a guardian or attorney is no longer applicable; their powers to consent to mental health treatment, care or support are limited to where the subject person complies with the treatment to be given.

Therefore, section 28(4) 28(5)(b) provide that a mental health professional may apply for an order. However, orders in either of these circumstances are limited in effect. Either the order provides authority to treat the person according to their advance consent direction, or it provides authority to give the person the particular treatment that is an alternative to the treatment regarded as unsafe.

Section 29 Ending advance agreement or advance consent direction specifies who may end a person's advance agreement or consent direction and how, as well as associated obligations on a member of a person's treating team who is told about the end of a person's advance agreement or consent direction by the person.

A person with decision-making capacity may end their advance agreement or their advance consent direction by telling a member of the

person's treating team, orally or in writing, that that is what they want, or by entering into another advance agreement or advance consent direction.

A member of a person's treating team who is told about a decision to end an advance agreement or an advance consent direction must ensure the information is entered in the person's record as soon as practicable , given to any member of the person's treating team who does not have access to the person's record and if the person has a nominated person, given to the nominated person. They must also give a copy of the information entered on the person's record, to the person.

Section 30 Effect of advance agreement and advance consent direction on guardian with authority to give consent for treatment, care or support limits the power a guardian may exercise in respect a person who has an advance agreement or an advance consent direction.

A guardian may only exercise their authority to provide consent where the decision requiring consent is not a matter that the person has addressed in their advance agreement or advance consent direction or where the treatment care or support proposed in the advance consent direction is deemed unsafe by the mental health professional and the person accepts alternative treatment.

Section 31 Effect of enduring power of attorney on previous advance agreement and advance consent direction limits the power an attorney may exercise in respect a person who has an advance agreement or an advance consent direction.

An attorney may only exercise their authority to provide consent where the person lacks capacity and decision requiring consent is not a matter that the person has addressed in their advance agreement or advance consent direction or where the person lacks capacity and treatment care or support proposed in the advance consent direction is deemed unsafe by the mental health professional and the person accepts alternative treatment.

Section 32 Effect of health direction on previous advance consent direction provides that if a person makes an advance consent direction and afterwards makes a health direction under the *Medical Treatment*

(Health Directions) Act 2006 (ACT) which deals with a matter mentioned in the advance consent direction, then the direction about the matter in the advance consent direction no longer applies.

For more on Part 3.3's provisions, see *3.1.3.3 Nominated persons, advance agreements, and advance consent directions*, an earlier section of this Explanatory Statement.

Chapter 4 Assessments is a new heading in the Act.

Part 4.1 Applications for assessment orders is a new heading in the Act. It is now placed before mental health orders to reflect more accurately the order of operations. Currently the ACAT considers an application for an order and then adjourns to seek an assessment. Now, applications will be made for assessments rather than orders and when the ACAT comes to consider making an order the assessment will be available.

This chapter provides one of two pathways for assessment. Persons may also be assessed as a result of apprehension and examination under Chapter 6 (Emergency detention).

Section 33 Applications by people with mental disorder or mental illness—assessment order provides that a person may apply for an assessment order in relation to themselves if they believe that they satisfy the criteria for the order. Section 33 replaces section 10 of the current Act, which permits a person to apply for a mental health order in relation to themselves, and differs only in that it is renumbered and its title uses the term 'mental disorder' instead of 'mental dysfunction'.

As is respectively provided by section 33's Notes 1 and 2:

- the requirements for applications to the ACAT are set out in section 10 of the *ACAT Act*; and
- if a form is approved for the application, under section 117 of the *ACAT Act*, the form must be used.

Section 34 Applications by other people—assessment order allows a person to apply for an assessment order in relation to another person if they believe on reasonable grounds that the criteria for such an order are satisfied. This section replaces section 11 of the current Act which allows a person to apply for a mental health order in relation to another person and does not differ except that it is renumbered and uses the term

'mental disorder', instead of 'mental dysfunction'.

Notes 1 and 2 to this provision respectively provide that:

- the requirements for applications to the ACAT are set out in section 10 of the *ACAT Act*; and
- if a form is approved for the application, under section 117 of the *ACAT Act*, the form must be used.

Section 35 Applications by referring officers – assessment order replaces section 13 of the current Act, which allows referring officers to apply for mental health orders.

Research from Australia and overseas shows that high rates of mental illness are evident at all points in the criminal justice system, including among people who are in contact with police; are arrested; are held in police cells or on remand; appear in court; are imprisoned; or have a past history of imprisonment.[150]

A 2013 study and report by the University of New South Wales[151] concluded that people with mental disorders and cognitive impairments are significantly over-represented in the criminal justice system, the likelihood being 3 to 9 times greater for this category of people to be in prison than their non-disabled counterparts in general. Of the 10,000 people in NSW prisons, 77% of people were estimated to have a mental health condition, including alcohol or other drug related disorders.

Principle 4 of the National Statement of Principles for Forensic Mental Health 2006, entitled 'access and early intervention' states:

A prisoner/young offender, whether remanded, sentenced or in police custody, should have timely referral and access to specialist mental health services when appropriate. Persons attending court who appear to be mentally ill, or about whom there is concern regarding their mental health, should have access to assessment by an appropriately trained mental health clinician. All persons entering a

[150] *Diversion and support of offenders with a mental illness: Guidelines for best practice*, National Justice CEOs Group and the Victorian Government Department of Justice, [2010], p. 2, http://www.aic.gov.au/media_library/aic/njceo/diversion_support.pdf

[151] Ruth McCausland, Eleen Baldry, *People with mental health disorders and cognitive impairments in the criminal justice system; cost benefit analysis of early support and diversion*, University of New South Wales, August 2013

custodial environment should be assessed with regard to their mental health needs and referral arranged accordingly. Prisoners/young offenders should be made aware of the availability of specialist mental health services.

Diversionary initiatives seek to decrease reoffending and recidivism, to improve health and social functioning, to reintegrate offenders into the community and ensure that less pressure is placed on the criminal justice system. In the ACT, there are no specific court based diversion programs for people with an intellectual disability, cognitive or psychosis disability or an acquired brain injury.

In some circumstances it may not be appropriate to prosecute, or continue to prosecute this category of persons, considering the nature and circumstance of the alleged offender, and the person's apparent mental disorder and mental illness.

People in this category are often highly vulnerable and in need of assessment of the mental health to determine whether they require treatment and care.

If the situation warrants, it may also be appropriate to use the emergency detention provisions in the *Mental Health (Treatment and Care) Act 1994*. The court may also consider the use of its power to refer a person alleged to have committed an offence to emergency assessment under section 309 of the *Crimes Act 1900 (ACT)*.

The term 'referring officer' includes:

- the police officer who arrests the person in connection with an offence, or is satisfied that there are sufficient grounds on which to charge the person in connection with an offence, or who charges the person in connection with an offence; or
- a member of the staff of the director of public prosecutions who is responsible for the prosecution of an offence against the person; or
- a person who supervises them as a condition of bail under the *Bail Act 1992*.

Subsection 35(4) defines 'alleged to have committed an offence' for the purposes of section 35 and states that a person is 'alleged to have committed an offence' if one of three criteria is met. These criteria are :

- the person is arrested in connection with an offence; or
- a police officer believes on reasonable grounds that there are sufficient grounds on which to charge the person in connection with an offence; or
- the person is charged in connection with an offence.

The terms 'mental disorder' or 'mental illness' as defined by section 7 of the *Mental Health (Treatment and Care) Act 1994* as amended by the Bill are used rather than 'mental impairment'. This is to ensure consistent language across the *Mental Health (Treatment and Care) Act 1994*.

Section 36 Applicant and referring officer to tell ACAT of risks—assessment order provides that if an applicant or a referring officer for an assessment order believes on reasonable grounds that anything to do with the application process is likely to substantially increase the risk to the person's health or safety or the risk of serious harm to others then they must advise the ACAT in their application of the belief and why they hold the belief

The ACAT must give a copy of the application to the chief psychiatrist.

Section 36 consolidates in one provision its equivalents in the current Act, sections 12 and 14. Further, it expands on what sections 12 and 14 provide in two ways.

First, whereas sections 12 and 14 respectively make the applicant's and referring officer's belief that the 'appearance of the subject person before the ACAT' is likely to substantially increase risk to the person's health and safety or the risk of serious harm to others, section 36 broadens it to a belief that 'anything to do with the application process' is likely to substantially increase the risk.

Second, section 36 requires that the person state not only their 'belief about the substantially increased risk', but also 'the basis' for it in the assessment order application. Conversely, sections 12 and 14 require only that the person state their belief. The purpose of the amendments is to allow the ACAT to respond appropriately to circumstances where the subject person's knowledge of the application for assessment is considered likely to give rise to a significant increased risk to the safety of the person or another person including the applicant. This section is part

of considering whether an emergency assessment order is to be made.

'Part 4.2 Assessment orders' is a new heading in the Act.

Section 36A Assessment orders replaces section 16 of the current Act and enables the ACAT to order an assessment of a person if one or more of four scenarios apply. They are where:

- the ACAT is satisfied that an application made under part 4.1 (sections 33-36) may be granted the ACAT reviews a mental health order in force in relation to the person under section 36ZQ (Review, amend or revoke mental health order) which is described under clause 11 below;
- the person is required to submit to the jurisdiction of the ACAT under a care and protection order or interim care and protection order or an interim therapeutic protection order (defined in the Act's dictionary);
- the person is required to submit to ACAT's jurisdiction under Part 13 of the *Crimes Act 1900* (ACT) which provides for matters related to unfitness to plead and mental impairment of in respect of offences against ACT criminal law or under Part 1B of the *Crimes Act 1914* (Cwth) which provides for, among other things, unfitness to be tried, acquittal because of mental illness, and summary disposition of, and sentencing alternatives for, persons with a mental illness or intellectual disability, in respect of offences against federal criminal law; or
- the ACAT reviews a detention order in force in relation to the person under section 72 (Immediate review of detention under court order) of the Act which is described at clause 56 below.
- Subsection 36A(d) refers to Part 13 of the *Crimes Act 1900* (ACT) which provides for matters related to unfitness to plead and mental impairment of in respect of offences against ACT criminal law and to Part 1B of the *Crimes Act 1914* (Cwth). Part 1B of the *Crimes Act 1914* (Cwth) provides for, among other things, unfitness to be tried, acquittal because of mental illness, and summary disposition of, and sentencing alternatives for, persons with a mental illness or intellectual disability, in respect of offences against federal criminal law.

As is provided in the Note on this section, if a person is assessed under an assessment order as having a mental disorder or illness, the ACAT may progress, without further application, to consideration of a mental health

order or forensic mental health order in relation to that person, as per sections 36V, 36ZD, 48ZA and 48ZH, described below.

Section 36B Consent for assessment order replaces section 17 in the current Act and provides that if the ACAT is considering ordering an assessment under subsections 36A(a) to 36A(c). The ACAT is obligated to take reasonable steps to tell the person in writing that the ACAT is considering ordering an assessment, that an assessment may lead to a treatment order and that if a treatment order is made at a later time, their rights in relation to treatment will be explained at that time. These provisions are new to the Act.

The ACAT must also take reasonable steps find out the opinion of the person and obtain their consent to the assessment.

However, subsection 36B(2) expressly enables the ACAT to order an assessment without the person's consent, notwithstanding the subsection 36B(1)(c) requirement that the ACAT take reasonable steps to obtain a person's consent to the assessment.

Section 36C Emergency assessment order enables the ACAT to order an emergency assessment of a person without complying with section 36B (consent for an assessment order) or section 79A (notice of hearing). The provision is new to the Act and provides the ACAT with a mechanism for appropriate action where a presidential member of the ACAT holds serious concerns about a person's safety, for example as a result of information provided under section 36.

As the Note to section 36C reminds, the section 6 Principles must be taken into account when exercising any function under the Act, including the function of making orders provided for by section 36C.

Section 36D Content and effect of assessment orders is similar to section 19 in the current Act. It describes the matters that an assessment order must address and what actions the assessment order authorises. An assessment order, including an emergency assessment order made under section 36C, must:

- state the nature of the assessment to be conducted;
- name the mental health facility at which the assessment is to be conducted and, if appropriate, the person who is to conduct the

assessment, and

- direct the person to be assessed to attend the facility and, if necessary and reasonable, stay there until the assessment has been conducted.

The order is required to direct the person in charge of the facility to which the person is taken to:

- if appropriate, admit the person to the facility to conduct the assessment;
- if necessary and reasonable, detain the person at the facility until the assessment has been conducted, and
- provide the assistance that is necessary and reasonable to conduct the assessment.

The order authorises the assessment to be conducted including any actions necessary and reasonable to conduct the assessment.

The ACAT is required to be satisfied, before making an assessment order or an emergency assessment order, that the facility proposed to undertake the assessment can do so and that if a person is proposed to undertake the assessment, that the person can do so. This is a new requirement in the Act.

Because a further application for a mental health order is not required where an assessment indicates that the person has a mental illness or disorder, the ACAT is required to inform the person subject to the assessment order (but not an emergency assessment order) of that fact and in a way that the person is most likely to understand. This is a new requirement in the Act.

Other differences between the current section 19 and the new section 36D include that the the words, 'and reasonable' are added after the words 'if necessary' at 36D(c), 36D (d)(ii) and 36D(d)(iii).

Section 36E Public advocate to be told about assessment orders compels the ACAT to tell the public advocate, in writing, about an assessment order made in relation to a person immediately after the order is made.

The public advocate is the officer appointed to be the public advocate under section 6 of the *Public Advocate Act 2005* (ACT).

Section 36F Time for conducting assessments replaces section 21 in the current Act. This provision limits the time the ACAT may grant for the conduct of assessments to less than 7 days after an order is made unless the ACAT is satisfied by clinical evidence that the assessment cannot be completed within the period the ACAT specified in the order. An application to the ACAT is required for an extension to the 7 day limit and the period of time may only be extended by a further 7 days.

The new section 36F clarifies the intention that the first period of time in which an assessment may be conducted is limited to 7 days *or earlier* after the assessment order is made.

Section 36G Removal order to conduct assessments replaces section 22 of the current Act. It sets out the circumstances in which the ACAT may make a removal order, what the order authorises, and what it must state.

Section 36G largely replicates the current section 22 but differs in the following respects. Section 36G:

- applies to emergency assessment orders as well as assessment orders;
- requires, that the ACAT satisfy itself, before making a removal order, that the person has been made aware of the assessment order;
- declares, that as well as the ACAT satisfying itself that the person has been made aware of the assessment order, it must also be satisfied that either the person has failed to comply with an assessment order and had no reasonable excuse for doing so, or that there are other circumstances in which it is appropriate to make the removal order; and
- substitutes the word 'apprehension' for 'arrest'.

Section 36H Executing removal order provides that a removal order may be executed by a police officer and that the police officer must, before removing the person, explain to them the purpose of the order.

Section 36H differs from the similar provision in the current Act, section 22A, in that it no longer includes the powers of entry, apprehension and removal. These powers, in respect of functions exercised under new section 36H, are now supplied by new subsections 139F and 140, described below.

Section 36I Contact with others imposes two obligations on the person in charge of a mental health facility to which a person has been admitted under an assessment order.

The first, required by subsection 36I(2), is that they must, as soon as practicable after admission of the person, tell the public advocate, in writing, that that has occurred.

The second, required by subsection 36I(3), is that they must ensure that, while at the facility, the person has access to facilities, and adequate opportunity, to contact a relative or friend, the public advocate, a lawyer, the person's nominated person.

This provision replaces section 22B in the current Act, and differs only in that it adds 'nominated person' to the list of people that the person must have 'access to facilities and adequate opportunity' to contact.

Section 36J Public advocate and lawyer to have access replicates exactly section 22C in the current Act. It requires that a person's lawyer and the Public Advocate have access to the person at any time and that the person in charge of the facility, if asked by the public advocate or the person's lawyer, give the reasonable assistance necessary to allow them to access the person.

Section 36K Person to be assessed to be told about the order replicates exactly section 22D in the current Act. The person in charge of the mental health facility to which a person is admitted under an assessment order must, before an assessment is conducted, ensure that the person to be assessed is told about the assessment order, including the process and possible outcome of an assessment, in a way that the person is likely to understand.

This obligation holds, even if the person to be assessed was present when the order was made.

Section 36L Copies of assessments provides when, and to whom, the person in charge of the mental health facility must give copies of an assessment or tell the outcome of an assessment conducted under an assessment order.

Section 36L is the same as the similar provision in section 22E of the current Act, except in two significant respects.

First, it adds to the list of people to whom a copy of the assessment must be given within seven days of completing the assessment. A copy must be given to the people with parental responsibility for the child under the *Children and Young People Act 2008*, Division 1.3.2 (Parental responsibility), in the event that the assessed person was a child. There is no equivalent item in the current Act.

Second, it adds that the outcome of the assessment must be told in writing to the person's nominated person, guardian under the *Guardianship Act*, and attorney under the *Powers of Attorney Act 2006*.

Section 36M Notice of outcome of assessments is a new provision and applies to applications or referrals for assessment orders made under sections 34 and 35.

This new section provides that the ACAT must notify an applicant, other than the person who was assessed, or a referring officer of the assessment's recommendations before considering whether to make a mental health order in relation to the person who was assessed.

The applicant or referring officer who is so notified may, within 48 hours of receiving the notice, give the ACAT information about the person's mental disorder or illness and/or the implications for the person or for other people of not considering a mental health order in relation to the person.

The ACAT is then obliged to consider any information provided under this provision when deciding whether to hold a hearing to consider making a mental health order in relation to the person.

Section 36N Definitions —ch 5 provides two definitions to be used for the purposes of the new Chapter 5 – Mental Health Orders.

The *relevant official*, for a psychiatric treatment order, means the chief psychiatrist and for a community care order means the care coordinator. This definition is in the current Act, but is now placed at the start of the chapter on mental health orders. *Relevant person* is new to the Act. A relevant person for a psychiatric treatment order is the chief psychiatrist or another person nominated by the chief psychiatrist, and for a community care order, a person with authority to give the treatment, care or support that is proposed to be given to the subject person of the order.

Section 36O Applications for mental health orders enables an application for a mental health order to be made instead of an application for an assessment order in limited circumstances and only by the relevant person as defined under section 36N and described above. In the current Act, a broader range of people may apply for mental health orders, including referring officers. That concept of a broad range of people applying to the ACAT in respect of a person they believe to have a mental illness or disorder now applies instead to assessment orders. Where the assessment order indicates the need, the matter can proceed to a hearing without a further application to ACAT. This means that an assessment will now be available when the ACAT begins consideration of whether a mental health order should be made. An assessment order will usually only be made where the person is unwilling to have an assessment voluntarily. If an assessment is available, the process for considering a mental health order will be initiated by the application for order.

The relevant person must reasonably believe that the person for whom they are seeking a mental health order is in fact a person in respect of whom the ACAT could reasonably make such an order. In other words, the applicant should be able to satisfy the ACAT in the application that the criteria that apply to the order sought are satisfied. The relevant person is required to address the criteria in their application.

As is reminded by the Note provided for this section, an application is not required for a person who has been assessed under an assessment order as having a mental illness or a mental disorder

The term ‘mental health orders’ used in the title of this section is defined in the current Act’s Dictionary as meaning psychiatric treatment orders, community care orders, and restriction orders; The Bill has neither altered the content of that definition nor changed where it appears in the Act.

Section 36P Applicant to tell ACAT of risks serves the same purpose as section 36 providing the relevant person an opportunity to advise the ACAT of a belief that ‘anything to do with the process of applying for the order’ is likely to substantially increase risk to the person’s health or safety or to the safety of another person. Sections 13 and 14 from the current Act are omitted. As described above, the new section 35 now does the work of section 13 and the new section 36 now does the work of section 14.

Division 4.2 (assessments) of the current Act is omitted. The assessment provisions are now placed at Part 4.2 in the amended Act, separately from, and in front of, mental health order provisions. This new position in the Act reflects the new order of events, which is that assessments occur before mental health orders begin to be considered. 'Division 4.3 Making of orders—preliminary matters' in the current Act is replaced with the heading 'Part 5.3 Making of orders—preliminary matters'.

The Act's current sections 23 to 27, all inclusive, are replaced with the following sections 36Q to 36U, all inclusive.

Section 36Q ACAT must consider assessment requires that the ACAT consider one of two kinds of assessment of a person, before making an order in relation to that person. Subsection 36Q(1) requires that the assessment be one that was conducted under an assessment order, or that it be another assessment that the ACAT considers appropriate.

This reflects section 23 in the current Act, but imposes an extra obligation on the ACAT to take into account how recently that assessment was conducted and permits the ACAT to consider making a mental health order even if the assessment recommends otherwise.

Section 36R Consultation by ACAT—mental health order replaces section 25 in the current act and expands the list of people and bodies with whom the ACAT must consult.

As well as the current provisions that require the ACAT to consult with parents or people with parental responsibility for a child, a guardian if the person has one and the person most likely to be responsible for providing the treatment, care or support; the ACAT must now also consult with the following people:

- the person's attorney under the *Powers of Attorney Act 2006*, if the person has one;
- the person's nominated person, if they have one;
- the person's health attorney, if they have one;
- the chief psychiatrist or care-coordinator if they are likely to be responsible for providing the treatment, care or support, which the ACAT is proposing to order;
- the Corrections director-general if the person is a detainee, a

person released on licence, or a person serving a community-based sentence;

- the director-general responsible for the supervision of the person under the *Bail Act 1992* if the person is covered by a bail order that includes a condition that the person accept supervision under subsection 25(4)(e) or section 25A of the *Bail Act 1992*;
- the director-general responsible for the administration of the *Children and Young People Act 2008* if the person is a child covered by a bail order that includes a condition that the child accept supervision under subsection 26(2) of the *Bail Act 1992* or a young detainee or a young offender serving a community-based sentence;
- the applicant for an assessment order if an assessment order under part 4.1 of the Act gave rise to the ACAT's consideration of making the mental health order.

Subsection 36R does not include the requirement in the current Act's subsection 25(3) that the ACAT satisfy itself that the proposed particular person or facility can provide the treatment, care or support, before making an order for that. That provision is now included at subsection 36T(2).

Subsection 36R(2) also imposes on the ACAT a new obligation. Before making a mental health order in relation to a person, the ACAT must write to a carer (if the person has one) for whom the ACAT has contact details to advise them that:

- a hearing will be held in relation to making the order; and
- the carer may apply to the ACAT to attend the hearing; and
- the carer may make a submission to the ACAT in relation to making the order.

Section 36S ACAT must hold hearing—mental health order requires that before making a mental health order in relation to a person, the ACAT will hold a hearing into the matter. This provision is identical to the one provided by the current Act's section 24.

Section 36T What ACAT must take into account—mental health order replaces section 26 in the current Act.

Section 36 extensively lists what the ACAT must take into account before making a mental health order and stipulates that the ACAT must have received certain information before it can make a certain kind of order.

Section 36T amends section 26 of the current Act by adding one matter for ACAT's consideration which is the plan for the person's proposed treatment, care or support that is required by subsection 36O(3) and deleting 5 subsections (s26 subsections f -i and m) relating to the person's rights, welfare, autonomy, living arrangements and cultural needs. The subject matter of the deleted subsections is now addressed through the new Principles at the front of the Act at section 6, particularly subsections 6(a), 6(c), 6(f) and 6(j). The principles apply throughout the Act.

Also, subsection 36T(2) stipulates that before the ACAT makes a mental health order for the provision of particular treatment, care or support at a stated facility or by a stated person, the ACAT must receive from the relevant official for the order, a written statement that the treatment, care or support can be performed at the stated facility or by the stated person.

Section 36U ACAT must not order particular treatment, care or support—mental health order prohibits the ACAT from ordering a particular form of treatment, care or support, in making a mental health order.

This replaces section 27, which forbids the ACAT ordering 'the administration of a particular drug' or making an order about 'the way a particular clinical procedure is to be carried out'.

'Division 4.4 Psychiatric treatment orders' is replaced with the heading 'Part 5.4 Psychiatric treatment orders' and the current Act's sections 28, 29 and 30 are replaced with the following three sections.

Section 36V Psychiatric treatment order specifies the people to whom the section applies and outlines the criteria that must be met before the ACAT may make such an order.

The criteria differ from those in section 28 of the current Act in three ways described below.

First, as well as having a mental illness, the person must also either

- have no decision-making capacity for giving consent to the treatment, care or support and refuse to *receive* the treatment, care or support or
- have decision-making capacity, but refuse to *consent* to the treatment, care or support.

Second, as well as being satisfied that because of the person's mental illness the person or someone else is likely to suffer serious harm, or the person is likely to suffer serious mental or physical deterioration, the ACAT must hold the view that:

- where a person has the decision-making capacity to consent, and
- refuses to consent to treatment, care or support,

the likelihood of serious harm, or the serious mental or physical deterioration, is of such a serious nature that it outweighs the person's right to refuse to consent.

Assessment of decision making capacity will be governed by a Code of Practice recognised under the Act (see Section 114). The issue of this criterion will be addressed in the Code.

The occasions where risk outweighs the persons assessed capacity are expected to be rare, for example where the person is believed to be contemplating a course of action which involving such risk to themselves or others that it casts doubt on whether enough is yet known about the persons decision making capacity.

Third, if an application has been made for a *forensic* mental health order, then the ACAT must be satisfied that a psychiatric treatment order should be made instead.

In all other respects the criteria for a psychiatric treatment order remain the same as the current Act.

Please note that under section 145A, three years after section 145A commences, the Minister responsible for this Act must review the operation of section 36V, including by way of inviting public submissions. Further, the Minister must present a report of the review to the ACT Legislative Assembly not later than four years after the day section 36V commences.

Section 36W Content of psychiatric treatment order provides what

such an order may and must include and what it must not include.

It differs to the current Act's similar provision, section 29, in one respect. A new subsection is inserted that requires that a psychiatric treatment order include a statement that the person must comply with any determination that the chief psychiatrist makes under section 36Z and be accompanied by a further statement about how the person meets the criteria at section 36Z for the order.

Section 36X Criteria for making restriction order with psychiatric treatment order sets out what the ACAT must be satisfied of to make a restriction order with a psychiatric treatment order.

It differs to the current Act's section 30 by setting out an extra criterion.

That is that the ACAT must be satisfied that the treatment, care or support to be provided under the psychiatric treatment order cannot be adequately provided in another way that would involve less restriction of the person's freedom of choice and movement.

Section 36Y Content of a restriction order made with psychiatric treatment order replaces section 31 of the current Act but differs in that it now states that a restriction order does not prevent the chief psychiatrist from granting leave to a person detained at a stated place.

Section 36Z Role of chief psychiatrist replaces section 32 of the current Act. It provides for the responsibilities of the chief psychiatrist in respect of a person subject to a psychiatric treatment order.

The new section differs from the current Act's in a number of respects.

A significant change is that the Chief Psychiatrist will need to include in the initial determination whether the person is to be admitted to a facility for their treatment and make a further determination if the person is to move from the community to a facility during the time of their order. This change enables ACAT oversight of the admission of subject people to facilities under the Chief Psychiatrist's powers. A determination is part of an order, so that failure to comply with location of treatment constitutes a breach of the order.

Determinations will also now indicate whether a person may be given leave from a facility.

Another significant change is that the Chief Psychiatrist is now required to

take all reasonable steps to consult a broader range of people than required in the current Act, before making a determination. As well as the person, their guardian and their attorney the list now includes any of the following that apply – any person with parental responsibility, the nominated person, the carer and the health attorney.

The Chief Psychiatrist is now obliged to take the views of these people into account, making a record of whether the person was consulted and their views or, if the person was not consulted, the reasons why, and provide copies of the determination to them people in addition to the ACAT and the Public Advocate as already provided for in section 32 of the current Act.

Sections 33, is replaced with new section 36ZA unchanged.

Sections 34 and 35 are replaced by new sections 36ZB and 36ZC.

Section 36ZB Action if psychiatric treatment order no longer appropriate—no longer person in relation to whom ACAT could make order imposes additional obligations on the chief psychiatrist. This new section 36ZB differs from the current section 34 in three respects.

Where the current Act requires only that the Chief Psychiatrist tell the ACAT and the Public Advocate if they are satisfied that a person is no longer a person for whom an order could be made, the new provisions at36ZBrequire the chief psychiatrist to give written notice that a person's psychiatric treatment order is no longer appropriate or their restriction order is no longer necessary to the person's primary carer, if the person has one, and the person's nominated person, if they have one..

The written notice must

- state the reasons why the chief psychiatrist is satisfied that the person is no longer someone in respect of whom the ACAT could make an order or that it is no longer necessary for them to be subject to a restriction order;
- ask whether the primary carer or nominated person is aware of any information that may be relevant to whether the psychiatric treatment order or restriction order continues to be appropriate;
- state that, subject to consideration of any information given by the carer or nominated person the chief psychiatrist must tell the ACAT and

public advocate that the person is no longer someone in respect of whom the ACAT could make an order or that it is no longer necessary for the person to be subject to a restriction order and that the ACAT will then review the psychiatric treatment order or restriction order; and

- tell the carer or nominated person that they are entitled to make a submission to the ACAT's review of the psychiatric treatment order or restriction order.

Then, if, after having taken into account any information given the chief psychiatrist is still satisfied that the person is no longer someone in respect of whom the ACAT could make an order or that it is no longer necessary for them to be under a restriction order, then the chief psychiatrist must advise the ACAT and the public advocate of their opinion and the reasons for it. As the Notes to new section 36ZB remind:

- section 36ZQ of the Act obliges the ACAT to review the order within 72 hours after being notified under this section; and
- if one or more forms are approved for section 36ZB, under section 146A of the Act, the form/s must be used.

Section 36ZC Powers in relation to psychiatric treatment order circumscribes the powers that the chief psychiatrist may exercise in respect of a person who is the subject of a psychiatric treatment order.

Section 36ZC differs from the current section 35 in nine ways.

First, the current section 35 applies to any person who is the subject of a psychiatric treatment order, whereas the new section 36ZC applies only to three scenarios. These are that a person who is the subject of a psychiatric treatment order is also a person who:

- is subject to a restriction order that requires them to be detained at a stated place; or
- is subject to a determination made by the chief psychiatrist that requires the person to be admitted to an approved mental health facility; or
- is detained at an approved mental health facility under section 36ZO, which addresses contraventions of mental health orders.

Second, while the new section 36ZCpreserves the power of the chief

psychiatrist to detain the person, it does not state, as the current section 35 does, what powers of entry, apprehension, and removal, the chief psychiatrist may exercise to detain the person. For why this is so, please see *6.6 Powers of entry, search and seizure and the reasonableness and justifiability of them*.

The third difference is that the place that the Chief Psychiatrist may detain a person under this section is now specified as 'an approved mental health facility' replacing the term 'certain premises' used in the current Act.

Fourth, the chief psychiatrist's current power to subject the person to the confinement or restraint that is necessary and reasonable to prevent them from causing harm to themselves or someone else, or to ensure that the person remains in custody under the order is now limited to the 'minimum' confinement or restraint that is necessary and reasonable. Fifth, the the power of the chief psychiatrist to determine that the person can be given leave from the facility is introduced to the Act, this is not expressed in any provision of the current Act.

Sixth, if the chief psychiatrist subjects a person to involuntary seclusion, a relevant doctor must examine the person at least once four-hourly; This is an altogether new obligation provided by the Bill.

Seventh, 'relevant doctor' is a newly defined term. For the purposes of section 36ZC the definition is 'a person employed at the place as a consultant psychiatrist, psychiatric registrar in consultation with a consultant psychiatrist, or another doctor in consultation with a consultant psychiatrist'. There is no term for this or a similar group of doctors in the current Act.

Eighth, if the chief psychiatrist determines that a person be given medication for the treatment of the person's mental illness, the chief psychiatrist may:

- approve appropriately trained people to give the medication and use, or authorise someone else to use, the force and assistance that is necessary and reasonable to give the medication.

The current Act contains no equivalent provision/s.

Ninth, three new requirements on the chief psychiatrist are imposed by

extending the current Act's section 35(4). The extensions are:

- the chief psychiatrist must enter in the person's record the fact of, and reasons for, not only any involuntary restraint and seclusion of a person - entries that are already required by the current Act - but also any forcible giving of medication to a person;
- the chief psychiatrist must tell the public advocate in writing within 12 hours after the person is subjected to the confinement or restraint, involuntary seclusion, or forcible giving of medication, whereas the current Act requires that the public advocate be told just about involuntary restraint and seclusion, and only within twenty-four hours, and
- the chief psychiatrist must keep a register of the confinement or restraint, involuntary seclusion, or forcible giving of medication, whereas under the current Act, only a register of involuntary restraint or seclusion is required.

Section 36ZD Community care order provides an extensive list of criteria to be met before the ACAT can make a community care order. It replaces section 36 in the current Act but differs in five respects.

First, it replaces all of the current section's mentions of 'mental dysfunction' and its derivatives with 'mental disorder'.

Second, application of the section is newly restricted to a person assessed under an assessment order or in relation to whom a mental health order application has been made under Part 4.2, or a person in relation to whom a forensic mental health order application has been made under Division 7.1.2.

Third, as well as having a mental disorder, the person must also either

- have no decision-making capacity for giving consent to the treatment, care or support and refuse to *receive* the treatment, care or support or
- have decision-making capacity, but refuse to *consent* to the treatment, care or support.

Fourth, as well as being satisfied that because of the person's mental illness the person or someone else is likely to suffer serious harm, or the person is likely to suffer serious mental or physical deterioration, the ACAT must hold the view that:

- where a person has the decision-making capacity to consent, and
- refuses to consent to treatment, care or support,

the likely serious harm, or the serious mental or physical deterioration, is of such a serious nature that it outweighs the person's right to refuse to consent.

Assessment of decision making capacity will be governed by a Code of Practice recognised under the Act (see Section 114). The issue of this criterion will be addressed in the Code.

The occasions where risk outweighs the persons assessed capacity are expected to be rare, for example where the person is believed to be contemplating a course of action which involving such risk to themselves or others that it casts doubt on whether enough is yet known about the persons decision making capacity.

Fifth, if an application has been made for a *forensic* community care order, then the ACAT must be satisfied that a community treatment order should be made instead.

In all other respects the criteria for a community care order remain the same as the current Act.

Please note that under section 145A, three years after section 145A commences, the Minister responsible for this Act must review the operation of section 36V, including by way of inviting public submissions. Further, the Minister must present a report of the review to the ACT Legislative Assembly not later than four years after the day section 36V commences.

Section 36ZE Content of community care order differs to the current Act's similar provision, section 36A, in one respect. A new subsection is inserted that requires that a community care order include a statement that the person must comply with any determination that the care coordinator makes under section 36ZH and be accompanied by a further statement about how the person meets the criteria at section 36ZF for the order.

Section 36ZF Criteria for making restriction order with community care order specifies when ACAT can make a restriction order with a community care order.

New section 36ZF is more prescriptive than the current Act's section 36B. It adds the requirement that to impose a restriction order, the ACAT must be satisfied that the treatment, care or support cannot be adequately provided in another way that would involve less restriction of the person's freedom of choice and movement.

New subsection 36ZF preserves the current section 36B requirement that the ACAT be satisfied that a restriction order is in the interests of the person's health or safety or public safety.

Section 36G Content of a restriction order made with community care order etc is amended by the insertion of the word 'approved' before 'community care facility' but is otherwise the same as section 36C in the current Act.

'Approved community care facility' is newly defined in the dictionary of the Bill as a community care facility that the Minister responsible for the Act approves as a community care facility.

Section 36ZH Role of care coordinator-community care order replaces the 36D in the current Act and states what the responsibilities of the care coordinator are in respect of a person who is the subject of a community care order.

It differs from the current section 36D in four respects.

First, the new section 36ZH extends on the list of persons the care coordinator must take all reasonable steps to consult before making a determination on a person. It does so by adding:

- each person with parental responsibility for the child under Division 1.3.2 of the *Children and Young People Act 2008*, if the person is a child;
- a carer, if the person has a carer;
- the nominated person, if the person has a nominated person; and
- the health attorney, if a health attorney is involved in the treatment, care or support of the person; and
- by including the subject person in this list rather than another list of people to be consulted, 'if practicable'. The latter is deleted from the Bill.

Second, a new obligation is imposed on the care coordinator to take into account the views of the people consulted under section 36ZH.

Third, the list of people to whom the care coordinator must give a copy of the determination, as soon as practicable, after making it is expanded from the ACAT and the public advocate to now include any of the following that apply:

- each person with parental responsibility for the child under Division 1.3.2 of the *Children and Young People Act 2008*;
- the person's guardian;
- the attorney;
- a nominated person, and
- a health attorney.

As the Note to this section reminds, if a form is approved under section 146A for a determination, the form must be used.

Sections 36F and 36G in the current Act are replaced with the following sections 36F and 36G.

Section 36ZJ Action if community care order no longer appropriate—no longer person in relation to whom ACAT could make order imposes additional obligationson the care coordinator. This new section differs to the current subsection 36F in three respects.

Where the current Act requires only that the Chief Psychiatrist tell the ACAT and the Public Advocate if they are satisfied that a person is no longer a person for whom an order could be made, the new provisions require the care coordinator to give written notice that a person's community care order is no longer appropriate, or that it is no longer necessary for them to be subject to a restriction order, to the person's primary carer, if the person has one, and the person's nominated person, if they have one.

The written notice must :

- state the reasons why the care coordinator is satisfied that the person is no longer someone in respect of whom the ACAT could make an order or that it is no longer necessary for them to be subject to a restriction order;

- ask whether the primary carer or nominated person is aware of any other information that may be relevant to whether the community care order or restriction order continues to be appropriate;
- state that subject to consideration of any information given under subsection 36ZJ(3)(b), the care coordinator must tell the ACAT and public advocate that the person is no longer someone in respect of whom the ACAT could make an order, or that it is no longer necessary for the person to be subject to a restriction order, and that the ACAT will then review the community care order or restriction order; and
- tell the primary carer or nominated person that they are entitled to make a submission to the ACAT's review of the community care order or restriction order.

Then, if after having taken into account any information given the care coordinator is still satisfied that the person is no longer someone in respect of whom the ACAT could make an order, or that it is no longer necessary for them to be subject to a restriction order, then the care coordinator must advise the ACAT and the public advocate of their opinion and the reasons for it..

As the Notes to new section 36ZJ remind:

- section 36ZQ of the Act obliges the ACAT to review the order within 72 hours after being notified under this section
- If one or more forms are approved for section 36ZJ, under section 146A of the Act, the form/s must be used.

Section 36ZK Powers in relation to community care order circumscribes the powers that the care coordinator may exercise in respect of a person who is the subject of a community care order;

New section 36ZK differs from the current section 36G in six ways.

First, while the new subsection 36ZKpreserves the power of the care coordinator to detain the person, itdoes not provide, as the current section 36G does, the powers of entry, apprehension, and removal that the care coordinator may exercise to detain the person. For why this is so, please see *6.6 Powers of entry, search and seizure and the reasonableness and justifiability of them*.

Second, the care coordinator's current power to subject the person to the

'confinement or restraint that is necessary and reasonable to prevent them from causing harm to themselves or someone else, or to ensure that the person remains in custody under the order is now limited to the 'minimum' confinement that is reasonable and necessary. Third, if the care coordinator subjects a person to involuntary seclusion, a relevant doctor must examine the person at least once four-hourly; this is an altogether new obligation provided by the Bill.

Fourth, 'relevant doctor' is a newly defined term. For the purposes of section 36ZK, the definition is 'a person employed at the place as a consultant psychiatrist, psychiatric registrar in consultation with a consultant psychiatrist, or another doctor in consultation with a consultant psychiatrist'. There is no term used for this group of doctors in the current Act.

Fifth, if a community care order authorizes the giving of medication for the treatment of the person's mental disorder, the care coordinator may:

- approve appropriately trained people to give the medication prescribed by a doctor in accordance with the order; and
- use, or authorise someone else to use, the force and assistance that is necessary and reasonable to give the medication.

The current Act contains no equivalent provision/s.

Sixth, three new requirements on the care coordinator are imposed by extending the current Act's section 36G(5). The extensions are:

- the care coordinator must enter in the person's record the fact of, and reasons for, not only involuntary restraint and seclusion of a person - entries that are already required by the current Act - but also of medication forcibly given to the person;
- the care coordinator must tell the public advocate in writing within twelve hours after the person is subjected to the confinement or restraint, involuntary seclusion, or forcible giving of medication, whereas the current Act just requires that the public advocate be told about involuntary restraint or seclusion and only within twenty-four hours; and
- the care coordinator must keep a register of the confinement or restraint, involuntary seclusion, or forcible giving of medication,

whereas under the current Act, only a register of involuntary restraint or seclusion is required.

The heading 'Division 4.6 Limits on communication' is renamed 'Part 5.6 Limits on communication'.

Clause 11 substitutes the current Act's sections 36H and 36I with the following sections 36ZL and 36ZM.

Section 36ZL Limits on communication provides for when and how it is permissible for a relevant official to impose limits on communication between a person and another person or persons.

There is no difference in the meaning of this new section and the current section 36H, except that the new section 36ZL stipulates that 'the relevant official must not impose a limit on communication by the person with someone authorised under a territory law to communicate with the person'.

Section 36ZM Offence—limits on communication provides for two offences for the relevant official failing to ensure two certain things, after imposing a communication limit on a person.

Both of these offences are new to the Act and they are both strict liability offences. Firstly, a relevant official has committed an offence, if they impose a communication limit on a person subject to a mental health order, and then fail to ensure that 'the person has reasonable access to facilities and adequate opportunity to contact the public advocate and the person's lawyer'.

The section provides for this offence a maximum penalty of 20 penalty units. Section 133 of the *Legislation Act 2001* defines a penalty unit. At the time of writing, subsection 133(2)(a) of the *Legislation Act 2001* states that a penalty unit for an offence committed by an individual is $140. Hence, the maximum penalty for this offence, at the time of writing is $2,800.

The dollar value of a penalty unit in the *Legislation Act 2001* can change and so section 133 should be checked by any reader who wishes to calculate the dollar value of this or any other penalty specified in the Act.

Secondly, a relevant official commits an offence if after imposing a communication limit, the public advocate or the person's lawyer asks the

relevant official to give any reasonable assistance necessary to allow the public advocate or lawyer to access the person and the relevant official does not ensure that the assistance is given.

The section provides that the maximum penalty for this offence is 50 penalty units. At the time of writing, this is $7,000.

Division 4.7, heading is replaced with 'Part 5.7 Duration, contravention and review of orders'.

Section 36ZN Duration of mental health orders replaces section 36J of the current Act. This section governs the duration of psychiatric treatment orders and restriction orders

There is only one change to this section, which is that the provision at 36J(2) of the current Act is removed from this Bill. Current subsection 36J(2) excludes the application of the section to 'an order made in relation to an offender with a mental impairment'. It need no longer apply to offenders, because the Bill's Chapter 7 newly provides forensic psychiatric treatment orders for offenders.

Section 36ZO Contravention of mental health order replaces section 36K in the current Act. This section permits and requires the relevant official to do certain actions when a person makes certain kinds of contraventions of a psychiatric treatment order or a community care order.

As indicated in the Examples provided for this section, the kinds of contraventions that this section is intended to cover include failing to attend a mental health facility for treatment, care or support or failing to return to the facility at the end of a period of leave granted by the chief psychiatrist.

As noted in the above description of section 36N, a ***relevant official*** for a psychiatric treatment order means the chief psychiatrist, and for a community care order, the care coordinator.

This section departs from the current Act's section 36K in the following respects.

Contraventions – absconding from facility are excluded from this provision because they are covered separately by new section 36ZP**.** New section 36ZP is explained below.

While the three step contravention process outlined in the current Act at section 36K is largely retained there are two amendments to its operation in the new Bill. First, the relevant official may only commence the contravention response process that is provided by section 36ZO 'within 7 days of a contravention'. The current Act provides no time limit on the commencement of the process. Second, the Bill now allows for a person who has contravened a community care order to be taken to a community care facility whereas the current Act requires that the person be taken to a mental health facility.

Where a person is required to be detained under this section, an authorized ambulance officer is now added to the list of people who may , apprehend and take them to an approved mental health facility or approved community care facility. Please see *3.2.2 Provisions enabling authorised ambulance paramedics*, for explanation of why the Bill enables authorised ambulance paramedics to perform the apprehension and removal permitted by section 36ZO. The current Act requires that the relevant official tell the ACAT and the public advocate of a person's detention under this section within 72 hours. It does not specify what information must be told to the ACAT or the public advocate. However, in the new provisions the relevant official must tell the ACAT and the public advocate four items of information, and within only 24 hours of the person being detained. They are:

- the detained person's name;
- the reasons they were detained;
- the name and address of the approved mental health facility or approved community care facility where the person is detained, and
- whether the restriction order has been contravened, if the mental health order includes a restriction order that restricts where a person must live.

The current subsection 36K(6) supplies the powers of entry, apprehension and removal that can be exercised to detain the person when the relevant official requires detention under section 36ZO. The new subsection 36ZO makes no mention of such powers, because they are now provided by new section 139F, explained under clause 119, below.

The note to this section reminds that the ACAT must review a mental

health order, if it receives a notice under subsection 36ZO(4)(d) stating that a person subject to a mental health order has contravened a restriction order included with the mental health order. (see section 36ZQ(3) review, amendment or revocation of mental health order)

For discussion of the importance of this provision to a person's recovery, please see *6.6 Powers of entry, search and seizure and the reasonableness and justifiability of them*.

Section 36ZP Contravention of mental health order—absconding from facility provides what may occur, if certain persons abscond from an approved mental health facility or approved community care facility.

This section is entirely new to the Act.

Section 36ZP applies if a person absconds from an approved mental health facility or approved community care facility, they are subject to a mental health order, and they are subject to a restriction order or a determination that requires them to be detained at the facility;

A police officer, authorised ambulance paramedic, mental health officer, or doctor may apprehend the person and take them to an approved mental health facility or approved community care facility. Note that clause 119's new subsections 139F(1)(c) and 139F(2) supply the powers of entry, apprehension and removal needed to do this.

A person who apprehends a person, under this section must tell the person why they are apprehending them.

The relevant official is required to tell the ACAT and public advocate, in writing:

- the name of the person detained;
- the reasons they were detained, and
- the name and address of the approved mental health facility or approved community care facility where the person is detained.

Section 36ZP dictates that the relevant official must tell the ACAT and the public advocate all three information items within twelve hours of the person being detained.

Section 36ZQ Review, amend or revoke mental health order replaces section 36L in the current Act and states when the ACAT may or

must review mental health orders and associated requirements.

This new section departs from the current Act, in two ways.

First, the ACAT must, within seventy-two hours, review a mental health order when it receives a notice under section 36ZP. Section 36ZP, described above, is a new section that governs contraventions of mental health orders by absconding from approved mental health facilities or approved community care facilities.

Second, the ACAT is enabled, as part of its conduct of the review, to consult the people listed at subsection 36R(1) and to not conduct a hearing.

Clause 12 - Part 5 heading and sections 37 to 41

Clause 12 replaces the current Act's Part 5 heading and sections 37 to 41A with a new heading 'Chapter 6 Emergency detention' and new sections 37-41AA. Throughout these sections the phrase 'approved health facility' is replaced with 'approved mental health facility'.

Section 37 Apprehension regulates when and how a person may be apprehended, because their mental illness or disorder is manifesting in a way that causes the apprehending person to hold a reasonable belief that the person may either:

- attempt suicide or attempt to seriously harm themselves or another person (police officers and authorized ambulance paramedics) or
- require immediate treatment, care or support; or deteriorate within 3 days to such an extent that the person would require immediate treatment, care or support (if the apprehending officer is a doctor or mental health officer).

This section differs from the equivalent section in the current Act in several ways.

First, it allows an authorised ambulance paramedic to apprehend a person, rather than only a police officer, *3.2.2 Provisions enabling authorised ambulance paramedics*, an earlier section of this Explanatory Statement, explains the rationale for endowing this power on authorised ambulance paramedics.

Second, the new section 37 makes no mention of the powers of entry,

apprehension and removal in the current subsection 37(4). This is because these powers, in respect of functions exercised under new section 37, are supplied by clause 119's new section 139F described below.

Section 38 Detention at approved mental health facility replaces section 38 in the current Act and differs in that the confinement and restraint that is authorised under the section is now limited to the 'minimum' that is necessary and reasonable. In all other respects, the section is consistent with the current Act.

Section 38A Copy of court order replicates section 38A in the current Act with no changes.

Section 39 Statement of Action taken replicates section 39 of the current Act with only one change. 'authorised ambulance paramedic' is inserted after 'police officer'. For more on this amendment, please see *3.2.2 Provisions enabling authorised ambulance paramedics*.

Section 40 Examination at approved mental health facility replaces section 40 in the current Act and expands significantly on the provisions relating to medical examination on detention at an approved mental health facility under section 38.

The Act currently requires a medical examination of a person detained under section 38 within four hours of their arrival at the facility, if they initially came voluntarily and were detained under subsection 38(2) or they were detained at the facility, after being brought to it under subsection 38(1).

New section 40 requires the same, but adds the following powers and requirements.

It is now a requirement that a 'relevant doctor' conduct the examination. This term is new to the Act and is defined by subsection 40(7) for the purposes of section 40 as 'a person employed at the place as a consultant psychiatrist, psychiatric registrar in consultation with a consultant psychiatrist, or another doctor in consultation with a consultant psychiatrist'.

If, for some reason, the person has not been examined within four hours under subsection then the person in charge of the facility may continue to

detain the person if one of three conditions are met. They are that the person in charge of the facility believes, on reasonable grounds, that if they release the person without an initial examination:

- the person's health or safety is, or is likely to be, substantially at risk, as provided by or
- the person will do serious harm to others; or
- the person will seriously endanger public safety.

If a person is detained under this power then the person in charge of the facility must immediately tell the chief psychiatrist that the person has been at the facility for four hours without an initial examination and the chief psychiatrist must conduct an initial examination of the person, as soon as possible and within two hours of being told about the detention.

Further, if the person has not been given an initial examination within two hours of the chief psychiatrist's notification under subsection 40(4)(a), the person in charge of the facility is obliged to:

- release the person; or
- if a court order requires that the person be detained at a correctional centre, release them into the custody of a police officer for transfer to a correctional centre,.

The person in charge of an approved mental health facility is obliged to 'tell the public advocate, in writing, about any failure to give a subject person an initial examination within the time required under subsections 40(2) or 40(4) and the reasons for the failure'.

In this section, the meaning of 'initial examination' is now defined and must be undertaken by the relevant doctor. An initial examination means:

- examining the person 'in person';
- considering 'the observations arising from the examination', and
- considering 'any other reliable and relevant information about the subject person's condition'.

Consideration by the relevant doctor of 'any other reliable and relevant information about the subject persons' condition' is specifically included because the person may not manifest behaviours that are symptomatic of

certain conditions while they are being examined, even though not long before, they did so in front of a reliable source who has relayed that to a staff member of the facility. Alternatively, the witness may be a staff member.

For example, a person may not be answering questions or denying any problem at the time they receive their initial examination. However:

- a police officer brought the person into the facility, under subsection 37(1), and so the person in charge of the facility was obliged to detain the person under subsection 38(1), and
- the police officer verbally reported to a facility staff member that they brought the person in after witnessing them engaging in behaviour that was highly dangerous to themselves or plausibly threatening to do so.

It could also be that a person who is passive during their initial examination was not long before, detained by a mental health officer, under subsection 38(2), because the officer witnessed them voluntarily attend the facility, only to say to a staff member, 'I'll have myself run over by a bus', and then start walking towards the exit.

Section 41 Authorisation of involuntary detention provides for involuntary detention of a person in certain circumstances narrowly defined by section 41, which involve the person refusing urgent treatment, care or support that they need for their mental illness or disorder.

There are three main differences between the new section 41 and its equivalent provision, section 41, in the current Act.

First, the new section 41 refers to 'treatment, care or support' wherever current section 41 refers to 'treatment or care'. Further, the new subsection 41(1)(a) adds 'and any other information' to 'on the basis of that examination'. The purpose of this addition is explained in the description of section 40, above.

Second, the Bill adds, at subsection 41(1)(b), that the person cannot be detained under the section unless a doctor other than the one who conducted the section 40 examination also examines the person and concludes, on the basis of their examination and any other information, that there are reasonable grounds for believing that:

- the person requires immediate treatment or care;
- the person has refused to receive that treatment, care or support;
- detention is necessary for the person's own health, safety, social or financial wellbeing or the protection of members of the public, and
- adequate treatment or care cannot be provided in a less restrictive environment.

This addition exceeds the requirements of the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991), particularly Principle 16(1). Principle 16(1) states that where a 'qualified mental health practitioner authorised by law' finds that a person's mental illness is 'severe' and they are refusing treatment for it and need to be involuntarily detained to receive it:

A second such mental health practitioner, independent of the first, is to be consulted. The involuntary admission or retention may not take place unless the second mental health practitioner concurs.[152]

Third, the Bill amends section 41 to enable people who meet the section 41 criteria to be involuntarily detained for a period of up to fourteen days. This is four more days than is allowed under the current Act. The Review concluded that this extension is necessary for the following reasons.

Under the current Act, a doctor may authorise a person's detention for up to three days if the person's condition meets certain criteria. Further, if the treating team considers that an extension of the doctor's authorisation of detention is needed to give the person treatment or care, a psychiatrist must apply for that extension to the ACAT and the ACAT may order that, on the expiration of the doctor's authorisation, the person will be detained for a further period not exceeding seven days.

Under current section 24 (and new section 36S), the ACAT is required to have a hearing on each application for a psychiatric treatment order, and under current (and new) section 85, the ACAT is required to give certain parties three days written notice of the hearing. This means that under

[152] The United Nations Principles for the protection of persons with mental illness and the improvement of mental health care. Adopted by General Assembly Resolution 46/119 of 17 December 1991 <http://www.ohchr.org/EN/ProfessionalInterest/Pages/PersonsWithMentalIllness.aspx>, accessed 13 September 2013.

the current Act the treating team has only seven days in which to make a decision about whether they will need a psychiatric treatment order to give them lawful authority to continue the person's involuntary treatment.

A person's liberty may be restricted for up to six months by such an order, under section 36J of the current Act and section 36ZN of the Bill.

As the Review Advisory Committee heard during its consultations and deliberations, a person typically needs to be in treatment for a longer initial period than this, for their treating team to satisfactorily assess whether the person will continue to need involuntary treatment, and, therefore, whether there needs to be an application to the ACAT for an order for the person.

People who have effectively had ten or fewer days treatment, at the time ACAT has a hearing on whether they will be the subject of an order, are usually still too unwell to adequately present their perspectives to the ACAT or to find and instruct a lawyer, or another advocate, to do that for them.

The time pressures exerted by the current section 41 on the person and their treating team give rise to some risks. Chief among these is that a person may be made subject to a psychiatric treatment order for a longer term than they might have been had:

- the treating team had more days to observe their responses to treatment, and
- the person had more days to benefit from treatment, before the ACAT hearing.

The increased period of detention enabled by the new provisions is accompanied by clause 126's new subsection 145A(4) which provides that:

- eighteen months after the day section 41 commences, the Minister responsible for the Act will review the further period permitted by subsection 41(3), including by inviting submissions from the public; and
- not later than two years after section 41 commences, the Minister will lay a report on the review before the ACT Legislative Assembly.

This reform is explained in more detail, earlier in this Explanatory Statement, under *3.3 Extension in permissible period for emergency*

detention.

New subsections 41(4) and 41(5) respectively preserve the current section's safeguards of:

- any person being able to apply to the ACAT for review of a doctor's authorisation of up to three days involuntary detention of a person and of an ACAT order extending that for a period of up to eleven days; and
- the ACAT being required to conduct the review within two working days after the day it receives the application for review.

Section 41AA Medical examination addresses the matters currently addressed by section 43 of the current Act. The new section stipulates what kind of medical examinations a person detained under subsection 41(1) must receive, including when and by whom.

Section 43, which is omitted from the Bill, currently compels the person in charge of an approved mental health facility to ensure that the person receives a proper physical and psychiatric examination, within 24 hours of the person being so detained. The new section 41AA is more prescriptive than section 43.

Section 41AA dictates:

- that the person must receive a 'thorough' physical examination by a doctor, the purpose of the examination being to identify any physical health issue the person may have, including anything that may be contributing to their presentation for psychiatric assessment;
- that the person must receive a 'thorough' psychiatric examination by a person employed at the facility as a consultant psychiatrist or by a psychiatric registrar in consultation with a consultant psychiatrist or by another doctor in consultation with a consultant psychiatrist; and
- that the examination must, as far as reasonably practicable, occur within 24 hours of the person being detained at the mental health facility.

Clause 13 Notification of Magistrates Court about emergency detention or release from emergency detention. Section 41A

This clause replaces 'approved health facility' in section 41A with 'approved mental health facility'.

Clause 14 Section 41A

Clause 14 replaces 'treatment or care' with 'treatment, care or support'.

Clause 15 New Section 41A(2)

This new subsection requires that when a person who was referred under the *Crimes Act 1900* (ACT) section 309 (1) (a) is detained at a facility under sections 38 or 41, the court is notified. Notification is already required to the Public Advocate and the ACAT under section 42(2).

Clause 16 Section 42 replaces section 42 of the current Act.

Section 42 provides that the doctor must provide 'required information' to the ACAT, the public advocate and the following people as they apply - the person's guardian, attorney, nominated person or health attorney (if a health attorney is involved in the treatment, care or support of the person). The ACAT and public advocate must be notified within twelve hours of authorising the involuntary detention of a person under sections 38 or 41 and attracts a penalty of 5 penalty units. Reasonable steps must be taken as soon as practicable to notify the remaining persons and again, a penalty of 5 penalty points applies.

The information required to be given is the name of the person, the reasons for authorizing the detention and the , name and address of the approved mental health facility where the person is detained.

Clause 17 Medical examination Section 4

Section 43 is omitted from the Act. New section 41AA addresses the same matters.

Clause 18 Treatment during detention Section 44(1)

The words 'care or support' are inserted after the word 'treatment' in subsection 44 (1).

Clause 19 Section 44(1), note

Clause 19 replaces '(see subdiv 7.2.4)', in the Note on Section 44 (1), with '(see div 9.2.4)'.

Clause 20 Section 44 (as amended)

Section 44 (as amended) is relocated so that it becomes section 41AB.

Clause 21 Section 45 heading

The current Act's section 45 heading is replaced with '45 Offence—communication during detention'.

Clauses 22 - 24 Section 45

In Section 45, the following substitutions occur:

'(the detainee)' is replaced with '(the detained person)'.

'detainee' is replaced with 'detained person'.

'detainee's lawyer' is replaced with 'detained person's lawyer'.

Clause 25 Orders for release Section 46(1)

This clause replaces 'may' in section 46 (1) with 'must, as soon as practicable'.

Clause 26 Section 46(2)

This clause replaces 'shall' in section 46 (2) with 'must, as soon as practicable'.

Clause 27 Approved facilities Section 48

Section 48 is omitted from the Act.

Clause 28 Divisions 5A.1 to 5A.5

Divisions 5A;1 to 5A;5 are renumbered as parts 15;1 to 15;5;

Clauses 29 and 30 Section 48A

The Section 48A heading is renamed 'Object of ch 15' and the term 'part' is replaced with 'chapter'.

Clause 31 and 32 Section 48B

The section 48B heading is renamed 'Definitions—ch 15' and the term 'part' is replaced with 'chapter'.

Clauses 33 – 42 part 5A Interstate Arrangements

These clauses deal with sections 48B, 48C, 48D, 48G, 48M, 48Q and 48R. Three changes are achieved with the amendments to these sections:

- the references within the sections to other provisions of this Act are updated to reflect amendments in this Bill;
- the terms 'division' and 'part' are substituted with 'part' and chapter' respectively; and

- Part 5A is relocated and renumbered as Chapter 15.

Clause 43 New chapters 7 and 8

This clause inserts new chapter 7 (Forensic Mental Health) and chapter 8 (Correctional Patients) into the *Mental Health (Treatment and Care) Act 1994*.

Part 7.1 Forensic Mental Health Orders sets out provisions for the making of forensic psychiatric treatment orders and forensic mental health orders.

Division 7.1.1 — Preliminary defines important terms for Part 7.1.

Division 7.1.2 Application for forensic mental health order sets out the application process for forensic mental health.

Section 48T provides that the chief psychiatrist, or their delegate, or a person authorised by the care coordinator may apply to the ACAT for a forensic mental health order. This division mirrors the equivalent division in Part 5.2 as amended by clause 11 of this Bill.

The applicant must believe on reasonable grounds that the person satisfies the criteria set out in for the ACAT to make a forensic mental health order. This section also requires that a plan setting out the proposed treatment, care or support of the subject person to mirror the equivalent section as amended in Chapter 5 (Mental Health Orders) at section 36O of the Bill.

Division 7.1.3 Making forensic mental health orders—preliminary matters sets out the preliminary matters for the making of forensic mental health orders. This division mirrors the equivalent as amended in Part 5.3 of this Bill.

Section 48Y What ACAT must take into account – forensic mental health order mirrors section 36T of the Bill in a number of ways.

For a person referred to the ACAT under the *Crimes Act 1900 (ACT)*, part 13, the ACAT must take into account the nature and circumstances of any offence related to the referral. The ACAT must take this issue into account when making a forensic mental health order or a mental health order.

This is important, as the ACAT is not required to make a forensic mental

health order for a person referred by a court.

The ACAT may only make a forensic mental health order if it is satisfied that, in the circumstances, a mental health order should not be made (see section 48ZA (2)(e)). This aspect of Chapter 7 is related to the notion that any measure used should be the minimum necessary to achieve the purpose of the order. This also relates to the object of the Act that care and support should be provided to people with a mental disorder or mental illness in a way that is least restricted or intrusive to them (see section 5(c)). In making a forensic mental health order the ACAT must also take into account that any restrictions placed on the person should be the minimum necessary for the safe and effective care of the person and protection of public safety.

There are also a number of important differences for ACAT in the matters that it must take in to account.

First, section 48Y(1)(g) requires the ACAT to take into account any statement by a registered affected person. An affected person is a person who has suffered harm because of an offence committed or alleged to have been committed by the person. The director-general must enter the person's name on the register where the criteria set out in section 48ZZH are satisfied. This is discussed further below at Part 7.3.

Similarly, where the matter relates to an order where there is a registered affected person, the views of the victims of crime commissioner must also be taken into account. This is an important requirement as it supports the commissioner's role with respect to advocacy for the rights and interests of victims of crime.

The second difference requires the ACAT to consider whether, if the person is not detained, public safety is likely to be seriously endangered. The likelihood of serious endangerment to public safety is a further criterion for forensic mental health orders (discussed above at *6.7 Human Rights Considerations – Forensic Mental Health*).

Before making a forensic mental health order for the particular treatment, care or support at a stated facility the ACAT must have a certificate from the relevant official that the treatment, care or support can be provided at the stated facility. This requirement has been included to ensure that a person's detention at a facility has been assessed as appropriate and that

the facility is able to admit the person to the facility.

Subsection (3) provides that if the treatment, care or support cannot be performed at the stated facility, the certificate may include options that the relevant person considers appropriate for the ACAT to consider in making the forensic mental health order. Subsection (4) requires the certificate to be given to the ACAT within 7 days after the ACAT makes the request, or longer time allowed by the ACAT. These sections provide for dialogue between the ACAT and the Chief Psychiatrist or the care coordinator in relation to the placement or detention of a person in mental health or community care facilities.

Section 48Z ACAT must not order particular treatment, care or support – forensic mental health order provides that the ACAT must not order a particular form of treatment care and support where it makes a forensic mental health order. This restriction supports the division of roles between the ACAT, which is responsible for making, and reviewing orders and the relevant officer who is responsible for the delivery and supervision of treatment, care and support.

Division 7.1.4 Forensic Psychiatric Treatment Orders provides the ACAT the power to make forensic psychiatric treatment orders and the powers, role and functions of the chief psychiatrist where an order has been made.

Section 48ZA Forensic Psychiatric Treatment Orders enables the ACAT to make a forensic psychiatric treatment order. Subsection (1) describes the classes of people for whom the ACAT may make a forensic psychiatric treatment orders.

Forensic psychiatric treatment orders may be made for the following people:

- detainees, or a person serving a community based sentence assessed under assessment orders;
- a detainee or a person serving community based sentences referred to ACAT for consideration of a forensic mental health order;
- a person required to submit to the jurisdiction of the ACAT for a under Part 13 of the *Crimes Act 1900* (ACT);
- a person required to submit to the jurisdiction of the ACAT under Part

1B of the *Crimes Act 1914* (Cwth).

The criteria for the making of forensic mental health orders are set out in subsection (2). The criteria for the making of a forensic psychiatric treatment orders can be summarised as follows:

- the person has a mental illness;
- the ACAT believes that because of the person's mental illness the person is doing or is likely to do themselves or someone harms or is suffering or is likely to suffer serious mental or physical deterioration;
- the person has seriously endangered or the person presents a risk of serious endangerment to public safety;
- the ACAT is satisfied that psychiatric treatment, care or support will reduce the harms and result in an improvement in the person's psychiatric condition;
- the ACAT is satisfied that a mental health order should not be made; and
- the ACAT is satisfied that the treatment, care or support to be provided cannot be provided in a in another way that would involve less restriction of the freedom of choice and movement of the person.

A forensic psychiatric treatment order restricts the freedom of movement and liberty for the person who has been placed on such an order.

Treating all people deprived of their liberty with humanity and with respect for their dignity is a fundamental and universally applicable rule to 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.[153]

Judicial considerations of human rights at a national and international level set out the following principles:

- The detention of the individual must be as a result of an identified mental illness or condition;
- The condition must warrant the confinement and must not be an

[153] Alexander, T, Bagaric, M & Faris, P , 2011 '*Australian Human Rights Law*', CCH Australia, page 292.

arbitrary deprivation of liberty;

- The detention of the mentally ill person must be proportionate and take into consideration humane treatment.

Section 48ZB Content of forensic psychiatric treatment order sets out the content of a forensic psychiatric treatment order and closely mirrors section 36W (Content of psychiatric treatment order) of this Bill.

The order may state an approved mental health facility to which the person may be admitted. The order must also state how the person meets the criteria for the order and that at the person must comply with a determination by the chief psychiatrist under section 48ZC.

The order may also state that the person must be detained at a stated approved mental health facility. This can be contrasted with psychiatric treatment orders where a 'restriction order' must be used where the ACAT requires that a person be detained at a stated facility. The ACAT must be satisfied that ordering detention in custody is appropriate in consideration of the criteria for the making of an order and must be satisfied that there is no less restrictive option available. The purpose of this distinction is to recognise the different criteria for the making of forensic mental health orders compared with mental health orders. The ACAT may also grant leave when making a forensic psychiatric treatment order. Leave is discussed further below in relation to division 7.1.8 (Leave for detained people).

The order may also state if the person must not approach a stated person, and if limitations are to be placed upon the person's communication.

There are clear limitations placed upon the person's liberty, freedom of movement and freedom of communication within the terms of an order. These limitations are proportionate, as they are part of the person's treatment and care, and is in the person's interest of the person receiving the treatment and care. Issues relating to limitations on human rights are discussed above at *6.7 Human Rights Considerations – Forensic Mental Health*.

Section 48ZC Role of the chief psychiatrist – forensic psychiatric treatment order provides the role of the chief psychiatrist where the ACAT makes a forensic psychiatric treatment order and closely mirrors

section 36Z (Role of chief psychiatrist—psychiatric treatment order) as amended by clause 11 of this Bill.

The Chief Psychiatrist is responsible for the treatment, care and support of the person. Within 5 working days of the making of a forensic psychiatric treatment order the chief psychiatrist must determine the treatment, care and support to be provided under the order. This may include that the person attend for treatment, care, and support and to undertake counselling, training, and therapeutic or rehabilitation programs.

The chief psychiatrist must take all reasonable steps to consult with people listed at subsection (5). This includes a requirement to consult with the person, their guardian, attorney and/or nominated person.

The view of the people consulted is to be taken into account by the chief psychiatrist in making a determination. This process is to assist the chief psychiatrist in ensuring that he or she has all relevant and important information when making a determination for a forensic mental health order for the person.

A copy of this determination is to be given to the person, the ACAT, the public advocate, and any of the following that apply: the person's guardian, nominated person and health attorney.

The limitations placed on a person's human rights by virtue of the chief psychiatrist's role are reasonable and proportionate. Issues relating to limitations on human rights are discussed above at *6.7 Human Rights Considerations – Forensic Mental Health*.

Section 48ZD Treatment etc under forensic psychiatric treatment order to be explained. The chief psychiatrist must explain to the person the nature and effects of the treatment, care or support, as stipulated on the forensic mental health order for the person, in a way in which the person is most likely to understand. This gives effect to the principles found at section 6 of the Act, including the person's right to be informed in a timely manner, to refuse treatment, and to be aware of their rights.

Where a person is to be admitted to a mental health facility or before receiving treatment at a facility a statement of the person's rights must be given to the person (see the Bill section 15 – Information to be given

to people). This statement includes the right to obtain a second opinion, to obtain legal advice and, if the person has decision-making capacity, to enter into advanced agreements and make advanced consent directions.

Section 48ZE Action if forensic psychiatric treatment order no longer appropriate – no longer person in relation to whom ACAT could make order provides a mechanism for the chief psychiatrist to inform the ACAT that a person currently on an order no longer meets the criteria for a forensic mental health order. This section serves an important function as it ensures that the ACAT is informed where a person's condition improves and they are unlikely to deteriorate without involuntary treatment. This section mirrors section 36ZB as amended by the Bill.

Where the chief psychiatrist forms the opinion that a person is no longer a person for whom the ACAT can make an order, the chief psychiatrist must give written notice to the primary carer and the nominated person indicating the reason for the chief psychiatrist's opinion. The notice must ask if the primary carer or nominated person is aware of any information relevant to the chief psychiatrist's decision. The notice must also extend an opportunity to the primary carer and nominated person to make a submission to the ACAT in relation to the decision made by the chief psychiatrist.

The ACAT must review the order within 10 days of being notified under this section. This requirement can be distinguished from the equivalent section for psychiatric treatment orders, which requires the ACAT to review the notice within 72 hours (section 36ZQas amended in the Bill). In reviewing a notice under this section the ACAT must hold a hearing and the ACAT must be constituted by a presidential member together with other members (see section 78(1)(f) as amended by clause 60 of the Bill).

Section 48ZF Action if forensic psychiatric treatment order no longer appropriate – no longer necessary to detain person provides a mechanism for the chief psychiatrist to inform the ACAT that a person currently detained under a forensic psychiatric treatment order no longer meets the criteria for that order.

Like section 48ZE above, this section serves an important function as it ensures that the ACAT is informed where a person's condition improves

and they are unlikely to deteriorate without involuntary treatment. This provision seeks to ensure that the person's freedoms, rights to liberty and freedom of movement are not restricted unreasonably.

This section also requires the chief psychiatrist to give notice to the person's primary carer and nominated person about the matters mentioned in subsection (3).

The ACAT must review the order within 10 days of being notified under this section. In reviewing a notice under this section the ACAT must hold a hearing and the ACAT must be constituted by a presidential member together with other members (see section 78(1)(f) as amended by clause 60 of the Bill).

Section 48ZG Powers in relation to forensic psychiatric treatment order gives the chief psychiatrist powers to detain a person in an approved mental health facility where the:

- ACAT has made an order requiring the person to be detain; or
- chief psychiatrist has made a determination that requires the person to be detain.

The chief psychiatrist may subject the person to the minimum confinement or restraint that is necessary and reasonable, including subjecting the person to involuntary seclusion, as a last resort.

The principle of the least restrictive option applies as reflected in section 5(c) (Objects of the Act) which ensures that people with a mental disorder or mental illness receive assessment and treatment, care or support in a way that is least restrictive or intrusive to them.

Involuntary seclusion restricts the person's rights to liberty and their freedom of movement. This restriction is proportionate, to be used as a last resort, assessed as necessary to prevent the person from causing harm to themself or someone else. Part of the conditions of the involuntary seclusion of the person includes an obligation placed upon the chief psychiatrist to ensure that the person is examined by a relevant doctor of the approved mental health facility at least once in each 4 hour period that the person is in seclusion.

The chief psychiatrist may also subject a person to confinement or restraint, involuntary seclusion or the forcible giving of medication. At

subsection (5) a number of requirement are imposed on the use of confinement, restraint, involuntary seclusion or the forcible giving of medication. In each of these circumstances, the chief psychiatrist must:

- enter relevant information in the person's record and the reason for the confinement or restraint;
- tell the Public Advocate for the ACT in writing within 12 hours after the confinement or restraint;
- keep a register of the confinement or restraint, involuntary seclusion or forcible giving of medication.

These measures provide transparency, accountability and scrutiny for the chief psychiatrist's decision to place the person in confinement or restraint, involuntary seclusion or the forcible giving of medication. These requirements also ensure that these measures are only used where necessary and appropriate and proportionate to the needs of the person. This supports section 19 of the *Human Rights Act 2004* that provides that anyone deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person.[154]

The detention of the person must be appropriate and proportionate to the needs of the mental health patient.

Division 7.1.5 – Forensic Community Care Orders provides the ACAT the power to make forensic community care orders and the powers, role and functions of the care coordinator where an order has been made.

Section 48ZH Forensic Community Care Orders enables the ACAT to make a forensic community care order. Subsection (1) describes the classes of people for whom the ACAT may make a forensic community care orders.

Forensic community care orders may be made for the following people:

- detainees, or a person serving a community based sentence assessed under assessment orders;

[154] The New Zealand Court of Appeal found that a breach of national and international standards with respect to confinement in a prisoners cell amounted to a breach of the right to be treated with humanity and with respect for the inherent dignity of the human person when deprived of liberty. See *Vogel v Attorney General & Ors* CA 171/2012 [2013] NZCA 545 (7 November 2013); http://www.commonlii.org/nz/cases/NZCA/2013/545.html

- a detainee or a person serving community based sentences referred to by ACAT for a forensic mental health order;
- a person required to submit to the jurisdiction of the ACAT under Part 13 of the *Crimes Act 1900* (ACT);
- a person required to submit to the jurisdiction of the ACAT under Part 1B of the *Crimes Act 1914* (Cwth).

The criteria for the making of forensic community care orders are set out in subsection (2). The criteria for the making of a forensic psychiatric treatment orders can be summarised as follows:

- the person has a mental disorder;
- the ACAT believes that because of the person's mental disorder the person is doing or is likely to do themselves or someone harms or is suffering or is likely to suffer serious mental or physical deterioration;
- the person has seriously endangered or the person presents a risk of serious endangerment to public safety;
- the ACAT is satisfied that treatment, care or support will reduce harm or the likelihood of harm;
- the ACAT is satisfied that a mental health order or a forensic mental health order should not be made; and
- the ACAT is satisfied that the treatment, care or support to be provided cannot be provided in a in another way that would involve less restriction of the freedom of choice and movement of the person.

A community care treatment order restricts the freedom of movement and liberty for the person who has been placed on such an order. Treating all people deprived of their liberty with humanity and with respect for their dignity is a fundamental and universally applicable rule to 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.[155]

Judicial considerations of human rights at a national and international level set out the following principles:

[155] Alexander, T, Bagaric, M & Faris, P , 2011 '*Australian Human Rights Law*', CCH Australia, page 292.

- The detention of the individual must be as a result of an identified mental illness or condition;
- The condition must warrant the confinement and must not be an arbitrary deprivation of liberty;
- The detention of the mentally ill person must be proportionate and take into consideration humane treatment.

Section 48ZI Content of forensic community care order sets out the content of a forensic community care order and closely mirrors section 36ZE (Content of community care order) as amended by clause 11 of this Bill.

The order may state an approved community care facility to which the person may be admitted. The order must also state how the person meets the criteria for the order and that at the person must comply with a determination by the care coordinator under section 48ZJ.

The order may also state that the person must be detained at a stated approved community care facility. This can be contrasted with community care orders where a 'restriction order' must be used where the ACAT requires that a person be detained at a stated facility. The ACAT must be satisfied that ordering detention in custody is appropriate in consideration of the criteria for the making of an order and must be satisfied that there is no less restrictive option available. The purpose of this distinction is to recognise the different criteria for the making of forensic community care orders compared with mental health orders. The ACAT may also grant leave when making a forensic community care order. Leave is discussed further below in relation to division 7.1.8 (Leave for detained people).

The order may also state if the person must not approach a stated person, and if limitations are to be placed upon the person's communication.

There are clear limitations placed upon the person's liberty, freedom of movement and freedom of communication within the terms of an order. These limitations are proportionate, as they are part of the person's treatment and care, and is in the person's interest of the person receiving the treatment and care. Issues relating to limitations on human rights are discussed above.

Section 48ZJ Role of care coordinator- forensic community care order provides the role of the care coordinator where the ACAT makes a forensic community care order and closely mirrors section 36ZH (Role of care coordinator—community care order) as amended by clause 11 of this Bill.

The care coordinator is responsible for coordinating the treatment, care and support of the person. Within 5 working days of the making of a forensic community care order the care coordinator must determine the treatment, care and support to be provided under the order.

This may include that the person attend for treatment, care, and support and to undertake counselling, training, and therapeutic or rehabilitation programs.

The care coordinator must take all reasonable steps to consult with people listed at subsection (5). This includes a requirement to consult with the person, their guardian, attorney and/or nominated person.

The view of the people consulted is to be taken into account by the care coordinator in making a determination. This process is to assist the care coordinator in ensuring that he or she has all relevant and important information when making a determination for a forensic community care order for the person.

A copy of this determination is to be given to the person, the ACAT, the public advocate their guardian, a nominated person and the health attorney consulted.

The limitations placed on a person's human rights by virtue of the care coordinator's role are reasonable and proportionate. Issues relating to limitations on human rights are discussed above.

Section 48ZK Treatment etc to be explained – forensic community care order. The care coordinator must explain to the person the nature and effects of the treatment, care or support, as stipulated on the forensic mental health order for the person, in a way in which the person is most likely to understand. This gives effect to the principles found at section 6 of the Act, including the person's right to be informed in a timely manner, to refuse treatment, and to be aware of their rights.

Section 48ZL Action if forensic community care order no longer

appropriate – no longer person in relation to whom ACAT could make order provides a mechanism for the care coordinator to inform the ACAT that a person currently on an order no longer meets the criteria for making a forensic community care order. This section serves an important function as it ensures that the ACAT is informed where a person's condition and circumstances improve and they are unlikely to deteriorate without involuntary treatment. This section mirrors section 36ZJ as amended by the Bill.

Where the care coordinator forms the opinion that person is no longer a person for whom the ACAT can make an order, the care coordinator must give written notice to the primary carer and the nominated person indicating the reason for the chief psychiatrist's opinion. The notice must ask if the primary carer or nominated person is aware of any information relevant to the care coordinator's decision. The notice must also extend an opportunity to the primary carer and nominated person to make a submission to the ACAT in relation to the decision made by the care coordinator.

The ACAT must review the order within 10 days of being notified under this section. This requirement can be distinguished from the equivalent section for community care orders which requires the ACAT to review the notice within 72 hours (section 36ZQ as amended in the Bill). In reviewing a notice under this section the ACAT must hold a hearing and the ACAT must be constituted by a presidential member together with other members (see section 78(1)(f) as amended by clause 60 of the Bill).

Section 48ZM Action if forensic community care order no longer appropriate – no longer necessary to detain person provides a mechanism for the care coordinator to inform the ACAT that a person currently detained under a forensic psychiatric treatment order no longer meets the criteria for that order.

Like section 48ZL above, this section serves an important function as it ensures that the ACAT is informed where a person's condition improves and they are unlikely to deteriorate without involuntary treatment. This provision seeks to ensure that the person's freedoms, rights to liberty and freedom of movement are not restricted unreasonably.

This section also requires the care coordinator to give notice to the

person's primary carer and nominated person about the matters mentioned in subsection (3).

The ACAT must review the order within 10 days of being notified under this section. In reviewing a notice under this section the ACAT must hold a hearing and the ACAT must be constituted by a presidential member together with other members (see section 78(1)(f) as amended by clause 60 of the Bill).

Section 48ZN Powers in relation to forensic community care order gives the care coordinator powers to detain a person in an approved community care facility where the:

- ACAT has made an order requiring the person to be detain; or
- care coordinator has made a determination that requires the person to be detain.

The care coordinator may subject the person to the minimum confinement or restraint that is necessary and reasonable, including subjecting the person to involuntary seclusion, as a last resort. The principle of the least restrictive option applies as reflected in section 5(c) (Objects of the Act) which ensures that people with a mental disorder or mental illness receive assessment and treatment, care or support in a way that is least restrictive or intrusive to them.

Involuntary seclusion restricts the person's rights to liberty and their freedom of movement. This restriction is proportionate, to be used as a last resort, assessed as necessary to prevent the person from causing harm to themself or someone else. Part of the conditions of the involuntary seclusion of the person includes an obligation placed upon the care coordinator to ensure that the person is examined by a relevant doctor of the approved community care facility at least once in each 4 hour period that the person is in seclusion.

The care coordinator may also subject a person to confinement or restraint, involuntary seclusion or the forcible giving of medication. At subsection (5) a number of requirement are imposed on the use of confinement, restraint, involuntary seclusion or the forcible giving of medication. In each of these circumstances, the care coordinator must:

- enter relevant information in the person's record and the reason for the

confinement or restraint;

- tell the Public Advocate for the ACT in writing within 12 hours after the confinement or restraint;
- keep a register of the confinement or restraint, involuntary seclusion or forcible giving of medication.

These measures provide transparency, accountability and scrutiny for the care coordinator's decision to place the person in confinement or restraint, involuntary seclusion or the forcible giving of medication. These requirements also ensure that these measures are only used where necessary and appropriate and proportionate to the needs of the person. This supports section 19 of the *Human Rights Act 2004* that provides that anyone deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person.[156]

The detention of the person must be appropriate and proportionate to the needs of the mental health patient.

Division 7.1.6 – Limits on communication under Forensic Mental Health Orders sets out limits that may be imposed on communication between a person subject to a forensic mental health order and another person for periods not exceeding 7 days. The division sets out the requirements and obligation on the relevant official (the chief psychiatrist or care coordinator) where a limitation is to be imposed.

A strict liability offence also serves to ensure that adequate access, opportunity and facilities to communicate with the Public Advocate for the ACT or the person's lawyer.

This division mirrors part 5.6, which allows limits on communication for mental health orders.

Section 48ZO Limits on communication – forensic mental health order allows the relevant official (the chief psychiatrist or care coordinator) to impose limits on community in the interests of the

[156] The New Zealand Court of Appeal found that a breach of national and international standards with respect to confinement in a prisoners cell amounted to a breach of the right to be treated with humanity and with respect for the inherent dignity of the human person when deprived of liberty. See *Vogel v Attorney General & Ors* CA 171/2012 [2013] NZCA 545 (7 November 2013); http://www.commonlii.org/nz/cases/NZCA/2013/545.html

effective, treatment care and support of a person subject to a forensic mental health order.

As a general rule, people with a mental illness or mental disorder have a right to communicate with people of their choice. The Bill proposes to formalise this right for people admitted to a mental health facility or community care facility at new section 17 (clause 11). An exception to this right is where the person responsible for the facility is complying with a limit imposed on communication between the admitted person and other people under this section (see subsection 17(3)).

After imposing limits on communication, the relevant official must explain to the person the nature of the limits, the period for which the limits will be in effect and the reason for imposing the limits. but is subject to penalties, where the offence of limiting the person's communication with their public advocate or their lawyer takes place.

Limits that may be imposed must not be imposed for a period longer than 7 days. The relevant official may impose a further period or periods limiting communication where necessary. The person subject to a limit on their communication with another person has the right to seek legal advice in relation to the limitation (see the Bill clause 11, section 15 (Information to be given to people) and apply for a review of the relevant official decision to ACAT (see section 48ZZ (Review, amendment or revocation of forensic mental health order).

The imposition of limitations placed on persons' communication is subject to the objects[157] and principles[158] of the *Mental Health (Treatment and Care) Act 1994* as amended by the Bill.

Section 48ZP Offence – limits on communication – forensic mental health order imposes a criminal offence on the relevant official where they fail to provide reasonable access to facilities and adequate opportunity or assistance and access to contact the public advocate for the ACT and the person's lawyer.

The offence carries a maximum penalty of 50 penalty units and is a strict liability offence.

[157] S5 of the *Mental Health (Treatment and Care) Act* 1994.

[158] S6 of the *Mental Health (Treatment and Care) Act* 1994.

The use of strict liability engages and limits the presumption of innocence as no fault element applies. This is appropriate as the powers, functions and responsibilities of the relevant official a clearly set out in the *Mental Health (Treatment and Care) Act 1994*.

Patients, especially those admitted involuntarily, have the right to communication with the outside world. If it is reasonably demonstrated that failure to restrict communications would be harmful to the patient's health or future prospects, or that such communications would impinge on the rights and freedoms of other people, then it may be reasonable to restrict those communications. The World Health Organisation's Resource Handbook of Mental Health[159] gives the example of when such measures may be justified, namely, when a patient makes repeated unpleasant telephone calls or sends letters to another person, or when a patient with a depressive illness writes and intends to send a letter of resignation to an employer. Legislation can set out the exceptional circumstances, as well as stipulating the right of people to appeal these restrictions.[160]

Division 7.1.7 Duration of Forensic Mental Health Orders

Section 48ZQ Duration of forensic mental health orders provides that a forensic mental health order remains in force for three months unless revoked sooner. Subsection (1)(b) provides that where consecutive forensic mental health orders remain in force for one year or more, the order may remain in force for up to a one year.

Section 48ZQ can be distinguished from section 36J in the current Act which provides that mental health orders remain in force for six months or three months where a restriction order has been made.

The approach taken in section 48ZQ is appropriate as it recognises that where the ACAT first makes an order the subject person's treatment and care will need a higher degree of scrutiny by the ACAT. Where a person has been the subject of an order for longer than 1 year, a duration of 1 year may be appropriate as the person's treatment and care will have stabilised. The ACAT may also make an order for a shorter period where

[159] World Health Organisation's Resource Book on Mental Health, Human Rights and Legislation, WHO Press, 2005.

[160] World Health Organisation's Resource Book on Mental Health, Human Rights and Legislation, WHO Press, 2005, p35.

appropriate.

Allowing a forensic mental health order to remain in force for 1 year engages and limits the same human rights set out above. This is because a person who has been subject to forensic mental health orders for 1 year or longer may be subject to an order for 1 year, as compared with 6 months for a mental health order. These limitations are proportionate for the same reasons set out above in relation to rights limited by part 7.

A key issue supporting the proportionality of the limits imposed by section 48ZQ is that forensic mental health orders can only be made where because of their mental illness or mental disorder the person has seriously endangered public safety.

Appropriate mechanisms are also in place to ensure that where a person's condition improves such that the ACAT may reconsider whether a forensic mental health order is no longer appropriate. These mechanisms include provisions a requirement for the chief psychiatrist and care coordinator to advice the ACAT where the person is not longer someone for whom the ACAT could make a forensic mental health order. The person the subject to an order may also apply to ACAT for a review of the order (section 48ZZ(1)).

A number of provisions have been added, in order to increase oversight of treatment and care of people subject to forensic mental health orders. These provisions bring together and clarify measures which were previously expressed in several different acts, and therefore were challenging to apply. The provisions aim to achieve an appropriate balance between protecting the safety of the community and protecting the rights of the individual in treatment.

Division 7.1.8 Leave for detained people allows the ACAT, the chief psychiatrist or the care coordinator (the relevant official) to grant leave to a person detained in an approved mental health facility or approved community care facility under a forensic mental health order in certain circumstances. The purposes of these new provisions are to support the oversight and supervision of approved absences and to support the rehabilitation and reintegration into the community.

This division sets out a tiered scheme for applications for the granting and revocation of leave recognising that the ACAT and the relevant official

may order detention. Where the ACAT makes an order detaining a person in an approved mental health facility or an approved community care facility, the ACAT may consider and grant leave. Where the relevant official determines that a person must be detained in a facility, that officer may approve leave.

A further class of leave may be granted by the relevant official in emergency or special circumstances. Given the nature of this type of leave this function may not be delegated.

Approved leave can serve a number of important purposes for people subject to detention under involuntary mental health orders. These purposes include maintaining links with the community, supporting rehabilitation and pre-release planning.

The *National Statement of Principles for Forensic Mental Health* (2006) recognises under principle 5 (comprehensive forensic mental health services) that one of the main functions of a forensic mental health service is the 'coordination of care across settings, including pre-release planning and linking clients with general mental health and private mental health services'.

The Victorian Forensic Leave Panel Annual Report (2012) describes the purpose of leave as 'to assist the rehabilitation process and provide a gradual progression towards a return to community living that is consistent with the needs of the individual and community safety'.

Psychiatrists, Courts and Tribunals make decisions about when leave is appropriate based on the person's clinical assessment at the relevant time taking into consideration the benefits for the person and the risks associated with the granting of leave. Other key considerations for the granting of leave are the views of the person and other people concerned with the person's treatment and care.

Given the relationship between orders for detention under forensic mental health orders and provisions allowing for the granting and revocation of leave these provisions also engage and limit the same rights as described above.

The limitations are reasonable and proportionate as they allow for a person subject to an order of detention to apply to the ACAT or to the relevant official for the granting of leave.

Decisions by the relevant official to refuse leave are reviewable decisions under proposed amendment to the list of reviewable decisions at schedule 1 (see clause 129).

This division also supports the right to freedom of movement (*Human Rights Act 2004*, section 13) and the right to liberty and security of the person (*Human Rights Act 2004*, section 18). This is because the availability of leave also ensures that any limitations on a detained person right to liberty and freedom of movement are the minimum necessary to support their treatment and care and ensure the public is not serious endangered.

Section 48ZR Definitions—division 7.1.8 defines the term 'corrections order'. This term is important given that where a corrections order is in place, the director-general for either the *Corrections Management Act 2007* or the *Children and Young People Act 2008* must be consulted before leave may be granted.

Section 48ZS Grant leave for person detained by ACAT allows the ACAT to grant leave for a person subject to a forensic mental health order where the ACAT has also made an order that requires that the person be detained at an approved mental health facility or approved community care facility.

Where the ACAT makes an order detaining a person in a relevant facility, the person may not be released from the facility for any purpose unless the ACAT grants leave under section 48ZS. The only exceptions to this are where:

- the person is required to attend a hearing at ACAT or court — whether criminal or civil; or
- the chief psychiatrist or the care coordinator grants leave in emergency or special circumstances which is discussed further below.

The ACAT may grant leave where the person or the chief psychiatrist or the care coordinator has applied. The ACAT must hold a hearing constituted by the presidential and other members of the ACAT (see proposed amendments in clause 60 to section 78 — When ACAT must be constituted by more members).

Before granting leave, the ACAT must consult with the director-general

for the *Corrections Management Act 2007* for an adult or the director-general for the *Children and Young People Act 2008* for a child or young person where the person is also subject to a corrections order.

The ACAT must also consult with the relevant official where the person applies for leave. The ACAT may also consult other parties on its own initiative.

The ACAT may grant leave for any purpose the ACAT considers appropriate. This can include leave for short social outings, to perform work, to attend a medical appointment outside the facility or for compassionate reasons such as visiting a close friend or relative. Leave may be granted for a period considered appropriate by the ACAT and may be granted for extended periods as part of a plan for rehabilitation including for the person's eventual discharge from detention at the facility. Leave may be accompanied or unaccompanied and may be subject to conditions as appropriate including conditions described in subsection (6).

The ACAT may only grant leave where it is satisfied that:

- no serious concerns have been raised about the appropriateness of the leave; and
- the safety of the person, anyone else, or the public will not be seriously endangered.

Under subsection 4(b) the ACAT may also refuse to grant leave where the person has applied for leave for the same purpose within the previous six months and the earlier application was refused. The purpose of this provision is to limit repeat applications for leave for the same purpose where leave has been refused because of concerns about appropriateness or risks of serious public endangerment. The ACAT may also deal with applications for leave that it considers frivolous or vexatious under section 32 of the *ACAT Act 2008*.

A non-exhaustive list of conditions that can be imposed by the ACAT is set out in subsection (6). Subsection (6)(a) provides that the ACAT may impose a condition that the person accept treatment, care and support as required. This is an important condition as it incorporates support in the form of accompanied leave.

Section 48ZT Revoke leave granted by ACAT allows the ACAT to revoke leave it has granted under section 48ZS on the application of the chief psychiatrist, care coordinator or the corrections director-general or on its own initiative.

The ACAT is required to give notice to parties listed at subsection (2). The ACAT is required to give notice to the person the subject of the order where the ACAT is considering an application for revocation of leave under this section.

Under subsection (5), where a person's leave is revoked under this section a police officer, an authorised ambulance paramedic, doctor or mental health officer may apprehend the person and take the person to a relevant facility. This engages and limits rights under the *Human Rights Act 2004* as set out above. These limitations are reasonable and proportionate for the same reasons set out above.

Where a person is on leave granted by the ACAT and circumstances arise such that chapter 6 (emergency detention) apply, a doctor a mental health officer, a police officer or an authorised ambulance paramedic may apprehend the person and take them to an approved mental health facility.

Section 48ZU Grant leave for person detained by relevant official allows the relevant official to grant leave for a person subject to a forensic mental health order where the person is required by the relevant official to be detained at an approved mental health facility or approved community care facility. This section mirrors section 48ZS which relates to the granting of leave for a person detained by ACAT.

Subsection (4) provides that the relevant official must not grant leave if the person has applied to the ACAT for leave for the same purpose and the ACAT has refused to grant the leave in the previous six months.

A decision by the relevant official to refuse leave under this section is a reviewable decision under proposed amendments to the list of reviewable decisions at schedule 1, item 1A (see clause 129).

Section 48ZV Leave in emergency or special circumstances allows the chief psychiatrist or care coordinator to grant leave in emergency or special circumstances to a person detained under a forensic mental health order in either an approved mental health facility or approved community

care facility under a forensic.

The chief psychiatrist or care coordinator may only grant leave under this section where satisfied that there are emergency or special circumstances for granting the leave and the person's safety or public safety will not be seriously endangered.

Whether emergency or special circumstances exist is a matter for the relevant official and can include attending a family member's funeral or a medical emergency. Where the purpose of leave can be anticipated, under normal circumstance, the person should apply for leave to either the ACAT or the relevant official.

Leave in emergency or special circumstances must not be granted where the ACAT or the relevant official has previously refused to grant leave under the same circumstances.

Under subsection (5) this function may not be delegated by the relevant official.

A decision by the relevant official to refuse leave under this section is a reviewable decision under proposed amendments to the list of reviewable decisions at schedule 1, item 1B (see clause 129).

Section 48ZW Revoke leave granted by relevant official allows the relevant official to revoke leave it has granted under section 48ZU or section 48ZV on the application of the corrections director-general or on their own initiative.

This section mirrors section 48ZT which relates to the revocation of leave granted to a person detained by ACAT.

A decision by the relevant official to revoke leave under this section is a reviewable decision under proposed amendments to the list of reviewable decisions at schedule 1, item 1C (see clause 129).

Under subsection (5), where a person's leave is revoked under this section a police officer, an authorised ambulance paramedic, doctor or mental health officer may apprehend the person and take the person to a relevant facility. This engages and limits rights under the *Human Rights Act 2004* as set out above at. These limitations are reasonable for the same reasons set out above.

Where a person is on leave granted by the ACAT and circumstances arise

such that chapter 6 (emergency detention) apply, a doctor, a mental health officer, a police officer or an ambulance paramedic may apprehend the person and take them to an approved mental health facility.

Division 7.1.9 Contravention and review of forensic mental health orders provides for the contravention and review of forensic mental health order with associated powers and responsibilities. This division mirrors relevant aspects of part 5.7 (Duration, contravention and review of mental health orders).

Section 48ZX Contravention of forensic mental health order allows the relevant official to respond to contraventions of a forensic mental health order. A continued contravention of an order can result in a person being apprehended and taken to a relevant facility for treatment, care or support.

If a forensic mental health order is in force, and the person contravenes a condition of the order, the relevant official is to orally tell the person, within 7 days of the contravention, that failure to comply with a condition of the order may result in the person being apprehended and taken to a relevant facility, for treatment, care or support.

If non compliance continues after the person is informed, the relevant official must tell the person in writing that failure to comply with the order will result in the person being apprehended and taken to a relevant facility for treatment, care or support. Further non-compliance from the person may result in the person being detained at a relevant facility to ensure compliance with the order.

This provision aims to balance the need to protect the safety of the community while continuing to protect the rights of the person requiring treatment, care and support.

The contravention of orders may have significant implications for the person, medically and to their safety, and to the safety of others. The detention of a person for a contravention of an order is a serious measure to be taken where other less restrictive options have either failed or will not achieve the purposes of the order.

This section engages and limits a person's right to liberty, and their of freedom movement. The limitation is reasonable and proportionate as the power is available to ensure the person's own safety, the safety of

others.

Where a person who has contravened a forensic mental health order and circumstances arise such that chapter 6 (emergency detention) apply, a doctor, a mental health officer, a police officer or an authorised ambulance paramedic may apprehend the person and take them to an approved mental health facility.

Section 48ZY Contravention of forensic mental health order – absconding from facility authorises a doctor, a mental health officer, a police officer or an authorised ambulance paramedic to apprehend a person who has absconded from an approved mental health facility or an approved community care facility.

The person must be told the reason for their apprehension. The person may also be searched, and items found on them may be seized under proposed new section 140 (see clause 119).

Within 12 hours after the detention starts, the relevant official must give written notice to the ACAT and the Public Advocate for the ACT with the name of the person, the reason for the detention, and the details of the facility where the person is detained,.

It is not a criminal offence to abscond from a mental health facility, and as such, the person absconding from a facility will not be subject to a criminal charge or conviction.

Section 48ZZ Review, amend or revoke forensic mental health order provides for the review, amendment and revocation of forensic mental health orders. The section provides that the ACAT must review an order where the person applies for a review on the basis that the order, or part of the order, is no longer required.

The ACAT also has a general discretion to review an order on its own initiative.

Subsection (3) also provides that the ACAT must review an order within 10 days where the relevant official gives the ACAT notice under section 48ZE, 48ZF, s48ZL or 48ZM. Notices under these sections must be given to ACAT where the chief psychiatrist or care coordinator forms an opinion that the ACAT could no longer make a forensic mental health order for the person.

The 10 day period for the review has been prescribed in subsection (3) to allow ACAT to consult with relevant parties, list a hearing and give notice about the hearing. The conduct of a hearing with consultation and notice ensures that the ACAT considers the relevant official's notice with all available information at its disposal. This ensures that the ACAT revokes orders only with the benefit of all relevant information, including information about whether the person will present risks of serious endangerment to community if the order is not place.

For matters under subsection (3) the ACAT must hold a hearing constituted by the presidential and other members of the ACAT (see proposed amendments in clause 60 to section 78 — When ACAT must be constituted by more members).

Part 7.2 Affected people provides mechanisms for information to be given to people affected by forensic patients. These provisions relate to victims (as defined in the ACT *Victims of Crime Act 1994*) of offending behaviour committed or alleged to have been committed by a person the subject of a forensic mental health order. These victims are referred to in the Bill as 'affected people'. The use of this term, as opposed to 'victim', underlines the therapeutic rather than punitive context of the ACT *Mental Health (Treatment and Care) Act 1994.* The use of this term also recognises the affected person's own role with respect to forensic mental health orders made by ACAT through the giving and receiving of information that is relevant to their own health and wellbeing.

People who have become victims of crime where the accused has a mental illness or mental disorder include family, carers, mental health workers, as well as other members of the public.

The substance of issues affecting victims of crime include fair recognition of their interests to information, acknowledgement and recognition of the harm caused and the on-going interest in their protection.

These rights are acknowledged in the United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power.

Provisions that specifically relate to affected people have been absent from the *Mental Health (Treatment and Care) Act 1994*. There has been limited existing scope for the views and concerns of affected persons to be considered in the context of an ACAT hearing for a mental health

order. This occurs through the ACAT's general discretion to give leave to any person with an interest in the matter to present a submission or appear before the Tribunal in relation to a mental health order.

Part 7.2 acknowledges the rights of affected people to have their views and concerns adequately addressed where ACAT is considering a forensic mental health order. Under the new provisions, the director-general may enter a person on a register of affected people where the director-general is satisfied that entering the information is necessary for the affected person's safety and wellbeing. Registered affected people are then entitled to certain information about the person subject to a forensic mental health order. This information includes where an application for a forensic mental health order has been made or is in force, where the person absconds or fails to return from approved leave and where the person is released from an approved mental health facility.

The provisions in part 7.3 together with other provision in chapter 7 relating to registered affected people are the least restrictive that that achieve the purpose of recognising the rights and needs of the affected person. The fact that the person must satisfy the director-general that registration is necessary and the limited scope of information that must be provided ensures that the provisions are the least restrictive means of achieving the purpose.

Part 7.2 also supports the rights of registered affected people by ensuring disclosure of relevant information. The right of registered affected people to have their concerns considered is also supported in provision in Part 7.1. Where the ACAT is considering the making of a forensic mental health order, the ACAT is required to consider any statement by the registered affected person and the views of the victims of crime commissioner (see section 48Y(1)(g) and (o)).

Section 48ZZA Definitions—pt7.2 defines important terms for part 7.2.

The term 'publish' is defined as it is relevant to the undertaking a person must give before being registered as an affected person.

Section 48ZZB Meaning of affected person defines the term affected person in relation to a forensic patient. An affected person is a person who suffers harm because of an offence committed, or alleged to have been committed, by the forensic patient. This term mirrors the definition

for ‘victim’ in section 6 of the *Victims of Crime Act* 1994, which is itself drawn from the application provision of the United Nations Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power.

The definition is inclusive and affected person is defined broadly, focusing on the harm suffered because of the offence rather than the relationship of other people to the victim who has suffered the initial, direct harm. It may include a person harmed by a previous offence committed by the person.

Section 48ZZC Meaning of registered affected person states that a registered affected person is an affected person whose information is entered in the register kept under section 48ZZD.

Section 48ZZD Affected person register provides that the director-general must maintain a register to be known as the ‘affected person register’.

Section 48ZZE Notifying people about the affected person register provides that the director-general must take reasonable steps to notify affected people in relation to forensic patients about the affected person register including the rights and obligations of registered affected people.

Section 48ZZF Including person in affected person register requires director-general to enter a person’s name on the affected person register where matters in subsection 48ZZF (1) have been satisfied. The person or their representative must make a request and give consent to their name being entered on the register as well as sign an undertaking not to publish information disclosed under section 48ZZH.

A key factor is that the director-general must be satisfied that that entering the information is necessary for the affected person’s safety and wellbeing (subsection (1)(c)). This means that information must be available to the director-general to allow this decision to be made. This information may include access to police reports or statements of facts, a health professional’s assessment about the harms experienced by the person or other relevant material.

The director-general must not disclose the information in the register about a registered affected person to the forensic patient.

Section 48ZZG Removing person from affected person requires the

director-general to remove a registered affected person's information from the affected person register on request by the person or someone with legal authority to act for the person.

The director-general may also remove a registered affected person's information from the affected person register if it is no longer necessary, for for the person's wellbeing and safety, to be a registered affected person. The director-general may also remove a registered affected person's information from the affected person register if the person breaches an undertaking not to publish information disclosed under section 48ZZH (Disclosures to registered affected people).

Before removing a registered affected person's information from the affected person register under subsection (2) the director-general must give written notice to the person and to the victims of crimes commissioner.

Section 48ZZH Disclosures to registered affected people gives the director-general explicit authority to disclose certain information to a registered affected person. This information is listed at subsection (2).

Subsection (3) also allows the director-general to disclose other information to a registered affected person in relation to the patient that the director-general considers necessary for the registered affected person's safety and wellbeing. This information could include information about the location or suburb where the forensic patient is to live and work once released from an approved mental health facility.

The director-general must ensure that any disclosure of information to a registered affected person is accompanied by a written statement that the person may not publish the disclosed information and that if the person discloses the information they may be removed from the register.

Part 8.1 Preliminary

Section 48ZZI Meaning of correctional patient defines 'correctional patient' as an important term for the Chapter and the Act. The term is defined to mean person in relation to whom a transfer direction has been made.

Part 8.2 Transfer of Correctional Patients

Section 48ZZJ Transfer to mental health facility provides for the

transfer of certain detainees to an approved mental health facility.

This will occur where a number of criteria are satisfied. First, the chief psychiatrist must be satisfied that a detainee has a mental illness for which treatment, care or support is available in an approved mental health facility.

Secondly, the detainee's circumstance must be such that the ACAT could not make a mental health order or forensic mental health order. The effect of this requirement is that the detainee must be consenting to mental health treatment, care and support at the approved mental health facility.

Where the chief psychiatrist requests that a detainee be transferred, subsection (3) requires the director-general for the *Corrections Management Act 2007* to make a direction for the transfer.

Section 48ZZK Return to correction centre unless direction to remain requires that a correction patient is to be returned to a correctional centre within 7 days of the transfer order unless the chief psychiatrist authorises a longer period under subsection (2).

Subsection (3) allows the chief psychiatrist to direct that the correction patient be returned to the correctional centre. The chief psychiatrist may give this direction where they are satisfied that the person no longer has a mental illness for which treatment, care or support is available in an approved mental health facility; or other care of an appropriate kind would be reasonably available to the person in a correctional centre.

The corrections director-general may give a direction for ensuring that a detainee charged from a health facility is returned to a correctional centre.[161]

Section 48ZZL Release etc on change of status of correctional patient provides that if a correctional patient is no longer subject to detention order under the criminal justice system, the director-general for the *Mental Health (Treatment and Care) Act 1994* must do one of the following things:

- continue the treatment, care and support at the facility where the person requests that it continue;

[161] S54(5) of the *Corrections Management Act* 2007.

- make a decision under the *Mental Health (Treatment and Care) Act 1994*; or
- release the person from the facility.

The requirement to do one of the things in subsection (2) will be contingent on the director-general for the *Mental Health (Treatment and Care) Act 1994* being told about the correction patients status. Subsection (1) includes a note to signpost the proposed new section in the *Corrections Management Act 2007*, section 54A(Transfer to mental health facility—transfer direction). New section 54A requires the director-general for that Act to tell the director-general responsible for the *Mental Health (Treatment and Care) Act 1994* in writing about any change in the detainee's status as a detainee.

Section 48ZZM ACAT may return people to correctional centre provides a right to correctional patients to apply to ACAT to be returned to a correctional centre.

If, on application, the ACAT is satisfied that the patient does not have a mental illness, or if the ACAT considers it appropriate, the ACAT must order the correctional patient be returned to a correctional centre.

Under subsection (4) the ACAT may, at any time on its own initiative, order the correctional patient be returned to a correctional centre if the ACAT considers it appropriate.

Part 8.3 Review of correctional patients

Section 48ZZN Review of correctional patient awaiting transfer to mental health facility provides a review mechanism for correctional patients who have not been transferred to an approved mental health facility. The purpose of this section is to provide appropriate scrutiny and oversight of transfer directions where the transfer has not occurred.

The ACAT must review the transfer direction after one month and each subsequent month until the person is transferred to an approved mental health facility or the transfer direction is revoked.

In order to support ACAT, the chief psychiatrist must give ACAT a report about the person's condition, the reason for the delay in transferring the person, and the availability and capacity of the approved mental health facility to accept the transfer.

Section 48ZZO Review of correctional patient transferred to mental health facility requires the ACAT to review the transfer direction as soon as practicable after the correctional patient has been transferred to an approved mental health facility. The purpose of this requirement is to ensure that transfers are appropriate to the circumstances of the correctional patient.

Section 48ZZP Review of correctional patient detained at mental health facility provides for the review of correctional patient transferred to an approved mental health facility under a transfer direction and detained at the facility for at least 6 months

The ACAT must review the transfer at the end of each 12 month period and at any other time at the request of people listed at subsection 48ZZP(2)(b) or on the ACAT's own initiative.

Part 8.4 Leave for Correctional Patients allows the director-general to grant a correctional patient leave from an approved mental health facility in certain circumstances. Leave may only be granted where there are special circumstances for granting the leave and the safety of the correctional patient, someone else or the public will not be seriously endangered.

This section supports a person's right to liberty and security of the person and right to family. The provisions support the ability for a person to obtain approved leave to undertake community based activities including to have contact with family members on important occasions.

Section 48ZZQ Grant of leave for correctional patients allows the director-general to grant leave for a correctional patient detained at an approved mental health facility. Before granting leave, the director-general must consult with the corrections director-general. This consultation will allow an opportunity to consider any information relevant to the question of whether the safety of the correctional patient, someone else or the public will be seriously endangered if leave is granted.

Subsection (2) provides that the grant of leave must state the purpose for which the leave is granted the period for which the leave is granted.

Subsection (3) allows the director-general to impose conditions on the granting of leave as appropriate.

Section 48ZZR Revoke leave for correctional patient allows the director-general to revoke leave it has granted under section 48ZZQ.

A decision by the director-general to revoke leave under this section is a reviewable decision under proposed amendments to the list of reviewable decisions at schedule 1, item 1E (see clause 129).

Under subsection (3), where a person's leave is revoked under this section a police officer, an authorised ambulance paramedic, doctor or mental health officer may apprehend the person and take the person to a relevant facility. This engages and limits rights under the *Human Rights Act 2004* as set out above. These limitations are reasonable for the same reasons set out above.

Where a person is on leave granted by the director-general and circumstances arise such that chapter 6 (emergency detention) apply, a doctor, a mental health officer, a police officer or an ambulance paramedic may apprehend the person and take them to an approved mental health facility.

Clause 44 Rights of mentally dysfunctional or mentally ill persons Part 6

This Part is omitted and reinserted at Chapter 3 of the Act**.**

Clauses 45 to 52 Part 7 Electroconvulsive Therapy and Psychiatric Surgery

These clauses amend parts of the current Part 7 of the Act, which deals with Electro Convulsive Therapy (ECT) and psychiatric surgery. Part 7 of the Act will become Chapter 9 in the amended Act and divisions 7.1 to 7.3 are renumbered as parts 9.1 to 9.3 while subdivisions 7.2.1 to 7.2.6 are renumbered as divisions 9.2.1 to 9.2.6.

Section 62 Application to be considered by committee has a new subsection (2) which requires that the people who, under the revised Act, may be involved in making substituted decisions for a person, or representing their view, are advised when the Chief Psychiatrist receives and application for psychosurgery.

Section 65(b) Consent of supreme court is amended to enable the Supreme Court to take into account the person's decision making capacity when considering an application for psychiatric surgery.

Section 66(3) Refusal of surgery is inserted to require that if a person refuses psychosurgery, the refusal is noted on the persons record.

Section 67(6) committees is inserted to require that members of the committee which considers applications for psychosurgery avoid as far as reasonable placing themselves in a position of conflict of interest by participating in the committee.

Clause 53 Part 8 Heading

This clause substitutes the heading for Part 8 relocating it as Chapter 10.

Clauses 54 and 55 Sections 68(8) and 70A

Section 68(8) Review of certain people found unfit to plead and Section 70A Recommendations about people with mental illness or mental dysfunction

'forensic mental health order' is inserted after 'mental health order' and 'dysfunction' is replaced with 'disorder'.

Clause 56 Sections 72 to 74

This clause substitutes sections 72 to 74.

Section 72 Review of detention under court order

This section applies to those under a court order, under Part 13 of the *Crimes Act 1900* (ACT), ordering that a person be detained in custody for immediate review by the ACAT.

This section seeks to clarify that detention in custody may only be continued where there are exceptional circumstances for the person that warrant continued detention.

ACAT must review the detention, and consider the release of the person as soon as possible and not later than 7 days of the court order.

The ACAT must also review the detention order as soon as practicable after the person has been in custody under the order for 1 month since the detention was last reviewed.

Amendments to section 72 will improve the rights focus of existing provision without compromising public safety.

The arbitrary deprivation of the right to liberty, as set out in section 18 of the *Human Rights Act 2004* 2004, is limited to the principle, which

respects the person's human dignity.

The immediate detention of the person ordered by the court ensures safety to the individual, as well as immediate safety to the public. The provision calls for an immediate review of the orders of detention to ensure that it is not arbitrary.

The Tribunal is to not only review the order, but to also consider the release of the person. The Tribunal is to have regard to the principle of last resort, noting that the order of detention is to be ordered in exceptional circumstances, taking into consideration the nature, extent and the likely effect of the mental illness or mental disorder on the person, and the likelihood of the person causing harm to themselves, or to others.

A key safeguard to protect a person's right against arbitrary deprivation of liberty is the new requirement for the ACAT to review detention under this section on a monthly basis. This ensures that any changes in the person's mental health during that period can properly be assessed and considered to determine whether ongoing detention is appropriate.

Immediate and subsequent monthly review will also give the ACAT an active role in the review of people with a mental impairment detained in custody. This role can include monitoring the establishment or availability of appropriate treatment and care options for the detained person.

The chief psychiatrist or the care coordinator will be responsible for the treatment, care and support of a person in relation to whom a mental health order or forensic mental health order has been made and remains in detention. In these circumstances, the ACAT will look to these office holders for advice and assistance on appropriate arrangements.

The person's rights not to be arbitrarily detained has been addressed in case law. A view that the detention of a person divorced from the criminal process is necessarily unjustifiable draws support from a statement by Brennan, Deane and Dawson JJ in Chu Kheng Lim v Minister for Immigration at 27-8162.

[162] *Chu Kheng Lim v Minister for Immigration, Local Government and Ethnic Affairs* (1992) 176 CLR 1 at 27-8.

Clause 57 Part 9 heading

This clause substitutes the heading for part 9 and relocates it as chapter 11.

Clauses 58 and 59 section 76

Replaces references to part 9 with chapter 11.

Clause 60 Sections 77 to 79

This clause substitutes and amends a number of sections, which deal with important procedural matters. Most amendments relate to the proposed new chapters 7 and 8 in clause 43. This clause also reorganises the sections to improve the logical sequence of the procedural requirements in chapter 11.

Section 77 When ACAT may be constituted by a presidential member is substituted with amendments to give effect to new provisions in chapters 7 and 8.

ACAT hearings may require more than one member of the tribunal (see section 78(2)). ACAT may be constituted by a presidential member alone for some urgent or more straightforward matters. This level of oversight by ACAT for these matters is therefore appropriate.

The proposed amendments to this section provide for a presidential member of ACAT to deal with some matters to do with new forensic mental health orders and new provisions for correctional patient.

Subsection (f) applies to periodic review of a correctional patient awaiting transfer from a corrections facility to a mental health facility.

Subsection (g) applies to review of a correctional patient who is currently in a mental health facility.

Section 78 When ACAT must be constituted by more members substitutes current section 78 with amendments to give effect to amendments in the Bill. Section 78 sets out the types of proceedings where the ACAT must be constituted by a presidential member *and* other members. These proceedings can be distinguished from urgent matters that may be dealt with a presidential member alone under section 77.

There are 3 new provisions in section 78. Subsection 1(c) requires more ACAT members (see 78(2)) to hear a proceeding relating to a forensic

mental health order. This includes applications for forensic mental health order and review of orders under the proposed section 48ZZ(2) (Review, amendment or revocation of forensic mental health order).

Sections 78 (1) (d) and (e) provide that more ACAT members hear any proceeding related to the granting or revocation of leave where leave is ordered by ACAT. This requirement ensures a fully constituted tribunal deals with question of about leave for forensic patient. This recognises that there will normally be significant concerns on the grounds of public endangerment where a forensic mental health order being considered or is already in place.

Section 79 Applications is substituted without amendments here. This section is an important procedural step at the beginning of the application process to ensure relevant office holders are given copies of applications. The Public Advocate for the ACT must receive a copy of all applications under the Act within 24 hours. The director-general for the *Children and Young People Act 2008* must receive all applications under the Act that involve a child.

Section 79A Notice of Hearing proposes to relocate existing section 85 with amendments to improve the logical sequence of the procedural requirements in chapter 11.

New subsection (1)(h) requires ACAT to give notice to a registered affected person and the victims of crime commissioner for relevant forensic mental health order hearings.

The proposed provisions relating to registered affect people at part 7.2 of the Bill is discussed above. The requirement to give notice to these parties supports the purposes of the proposed amendments relating to affected people.

This new requirement engages and limits the subject person's right to privacy and reputation (section 12, *Human Rights Act 2004*). This limitation is reasonable and proportionate for the same reason discuss above in the explanatory material for part 7.2. This new requirement also supports the right to liberty and security of the person for the affected person (section 18, *Human Rights Act 2004*). This is because it gives the registered affected person notice about a proceeding that has the potential to affect their health and wellbeing. With notice, the registered

affected person will have the opportunity to make a submission about any matter relevant to the proceeding that affected their health and wellbeing.

Subsection 79A (2) proposes a provision to allow the ACAT to suspend the giving of notice for a proceeding if a presidential member of the ACAT is sufficiently concerned, following written advice from the chief psychiatrist, that anything to do with the notification process is likely to substantially increase the risk to the person who is the subject of the proceeding, or the risk to someone else.

Examples of such a risk are where there are grounds for concern that the subject person may harm themselves when notified of the proceeding, or harm the applicant, or where delaying treatment for the notification period may seriously risk the health or wellbeing of the subject person.

The ACAT must provide the Public Advocate with a copy of the Chief Psychiatrists advice and tell the Public Advocate that notice has not been given. This gives the Public Advocate oversight of the matter and an opportunity to advocate for the subject person.

Subsection 79A(3) excludes applications for emergency assessment under section 36C and applications for emergency ECT under Section 55N from consideration under this section because they are each specifically provided for under those sections.

Clause 61 Appearance Section 80(1)(b) to (d)

This clause substitutes subsection 80(1)(d) with amendments to give effect to proposed amendments in the Bill involving attorneys, nominated people, referrals and registered affected people.

The effect of the proposed amendments to section 80 is that an attorney, a nominated person, a referred officer under section 35, a registered affected person and the victims of crime commissioner have a right of appearance at a relevant hearing.

Clause 62 Section 80(1)(g)

This clause makes a minor amendment to the subsection in line with the proposed change to how mental disorders are to be described.

Clause 63 Section 81 Separate representation of children etc

This clause substitutes current section 82 with amendments to expand the

circumstances where the ACAT may adjourn a proceeding to allow the person to obtain representation. The existing section limits the circumstances where the ACAT may adjourn a proceeding to allow a person to obtain advice and representation to children.

While the ACAT has an existing broad discretion for the way it conducts proceedings, particularly with respect to achieving justice for the subject person (see in particular the *ACAT Act*, section 6 — Principles applying to Act) this amendment ensure that, where appropriate, the ACAT is able to adjourn proceeding so that the person can access representation, advice and assistance.

Clause 64 Directions to registrar Section 84(2)

This clause proposes a minor amendment to reflect amendments in the Bill.

Clause 65 Section 84 (as amended)

This clause relocated former section 84 as amended to section 79A to improve the logical sequence of the procedural requirements in chapter 11.

Clause 66 Notice of hearing Section 85

This clause removes section 85 which has been remade at located at proposed section 79A to improve the logical sequence of the procedural requirements in chapter 11.

Clause 67 Section 86

This clause substitutes section 86 (Hearings to be held in private) with amendments to conform to current drafting practice.

Clause 68 Who is given a copy of the order? Section 87(1)(c)

This clause amends Section 87(1)(c) to clarify that where the subject of an order is a child, each person with parental responsibility must be given a copy of the order.

Clause 69 Section 87(1)(g)

This clause amends section 87(1)(g) to use consistent language with respect to a referring officer under section 35. The clause includes a requirement for ACAT to give a copy of an order to the chief psychiatrist and the corrections director-general where the application for a forensic

mental health order was made under section 48T (Applications to ACAT for forensic mental health order—detainees and people under community-based sentence).

Clause 70 Section 87(1)(i)

Removes reference to 'institution' at 87(1)(i) because this term is no longer used. The term 'facility' is also used in this section and is the correct term.

Clause 71 New section 87(1)(k)

This clause insert new inserts 87(1)(k) to require the ACAT to provide a nominated person with a copy of an ACAT order.

Clause 72 New section 87(2)(ba)

This clause inserts a requirement for ACAT to give a copy of a forensic psychiatric treatment order to the chief psychiatrist who is responsible for providing treatment, care and support under the order.

Clause 73 New section 87(3)(c)

This clause inserts a requirement for ACAT to give a copy of a forensic community care order to the care coordinator who is responsible for coordinating the treatment, care and support under the order.

Clause 74 Part 10 heading

Provides a new chapter 12 heading 'Administration' to improve understanding of how the provisions of the Act are set out.

Clause 75 and 76 Functions Section 113

'or support' is inserted after 'care' and a new section 113(c) is inserted to provide that the Chief Psychiatrist's powers include any other function given under the Act.

Clause 77 new section 114 Approved code of practice

This clause inserts a provision enabling the Chief Psychiatrist to approve a code of practice that will guide assessment of decision making capacity.

Clause 78 Section 116

Under current Section 116 the Minister may end the appointment of the Chief Psychiatrist for mental incapacity. This amendment limits the Minsters power to where such incapacity substantially affects the exercise

of the Chief Psychiatrist's functions.

Clause 79 Delegation by Chief Psychiatrist New section 118(2)

Most of the Chief Psychiatrist's powers under the Act can be delegated. Section 118(2) requires that the power to grant leave to a person who is subject to a forensic mental health order cannot be delegated. The restriction aims to ensure that any risk to public safety is properly considered.

Clause 80 Mental health officers Section 119(3), new definitions

Inserts definitions for psychologist and social worker.

Clause 81 Chief Psychiatrist's annual report Section 120(b)

This amendment replaces the reference to New South Wales with a reference to other states.

Clause 82 Care coordinator Part 10A

Part 10A is renumbered as part 12.2 in the amendment bill.

Clause 83 Sections 120B and 120C

Section 120B Functions (of the Care Coordinator). Now includes two new roles (c) (iii) to coordinate the provision of appropriate residential facilities under a forensic community care order, and (f) any other function given to the Care Coordinator under this Act.

Section 120C Ending appointment – Care Coordinator. Similar to the new provision for the Chief Psychiatrist, the Minister's power to end the appointment of the Care Coordinator for incapacity under subsection (1) (b) has been restricted to where the incapacity substantially affects the exercise of the Care Coordinator's functions.

Clause 84 Section 120D(2) Delegation by the Care Coordinator.

The Care Coordinators powers can be powers under the Act can be delegated in the circumstances set out in subsection (2)(b) A new Section 120(2) (a) requires that the power to grant leave to a person who is subject to a forensic community care order cannot be delegated. The restriction aims to ensure that any risk to public safety is properly considered.

Clause 85 Care coordinator's annual report Section 120E

This clause omits ‘dysfunction’ replacing it with ‘disorder’.

Clause 86 Official visitors Part 11

Part 11 is renumbered as part 12.3.

Clause 87 - 88 Meaning of *official visitor* etc Section 121

The term ‘dysfunction’ is replaced with ‘disorder’. The word ‘support’ is inserted after ‘treatment or care’.

Clause 89 Section 122(d)

‘Disorder’ is substituted for ‘Dysfunction’.

Clause 90 New section 122AA Appointment of Principal Official Visitor

This clause enables the Minister to appoint a Principal Official Visitor whose functions are set out in new Section 122AA.

Clauses 91 – 93 Section 122A

‘Disorder’ is substituted for ‘Dysfunction’ and treatment care or support’ is substituted for ‘treatment or care’.

Subsection (d) reinstates a power for an official visitor to consider any other matter the official visitor considers appropriate. This is a correction as the provision was previously part of the Act, but unintentionally removed when making amendments as part of the introduction of the *Official Visitor Act 2012*

Clause 94 New section 122BB. Principle Official Visitor – functions

This clause sets out the functions of the Principal Official Visitor.

Clauses 95 – 98 sections 122B and 122C

Substitute ‘treatment, care or support’, for ‘treatment or support’ and ‘disorder’ for ‘dysfunction’.

Clause 99 New Part 12.4 and new part 12.5 Clause 99 covers sections 122D to 122J dealing with the new role of a coordinating director-general and the way in which government agencies may share relevant information about a person for whom it is necessary for the safe and effective care of the person.

Part 12.4 Coordinating director-general

New Section 122D Coordinating director-general provides that the Chief Minister may appoint a director-general to be a coordinating director-general.

New Sections 122E Functions of coordinating director-general and 122F Coordinating director-general policies and operating procedures set out the functions and role of a coordinating director-general. The appointment supports a coordinating director-general to enlist the co-operation of agencies across government where this cooperation is important for the objectives of the Act, such as to build psychosocial support for recovery, or to develop activities which address the social determinants of community mental health and wellbeing.

Part 12.5 Sharing Information – government agencies

Section 122G Definitions – pt 12.5 defines important terms for this part.

Section 122H Information sharing protocol provides that information sharing entities, such as government directorates may enter into an arrangement to share information, for the purpose and benefit of the person's treatment, care and support. The effect of the protocol is that information sharing entities can request and receive relevant information held by each other entity, disclosing that information to the other entity, as relevant and necessary. The sharing of such sensitive information is to be shared to the extent that it is reasonably necessary for the safe and effective care of the person to whom the information relates, and can be done so, without the consent of the person to whom it relates.

The provisions of the *Health Records (Access and Privacy) Act* 1997must be taken into account in sharing information. However, section 122H(3) allows for the sharing of information without the persons consent if they are subject to a forensic mental health order.

A further purpose of this provision is to ensure that agencies with responsibility for the treatment, care and support of a person the subject of a forensic mental health order ensure the public safety is not endangered by the person.

The information sharing entity carries the responsibility of telling the person's guardian, the person's attorney, or the person's nominated person, where information is shared in the absence of the person consent.

People with mental illness and/or mental disorder 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 Australian Human Rights Commission, 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. The *Mental Health Legislation Amendment (Forensic Provisions) Act 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.

This provision engages and limits the right to privacy and reputation (section 12, *Human Rights Act 2004*).

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 and reputation. The comment notes that the term 'unlawful' means that no interference can take place except in cases envisaged by the law[163]. 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.[164] 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).

Section 122I information sharing guidelines

The Minister may make guidelines about the operation of the information sharing protocols.

Section 122J Information sharing – approval of agency

This provision allows the director-general to approve an agency from another jurisdiction as an information sharing entity for this part.

Clause 100 Part 12 heading

Part 12 in the current Act has 5 divisions. The heading and divisions 12.1 to 12.3 will now be included in a renamed Chapter 13. Divisions 12.4 and 12.5 are relocated to a new chapter 16.

Clauses 101 - 102 Definitions – ch 13 and Section 124 Owner or manager to be licensed

The definitions at section 123 are replicated from section 123 of the current Act with one change, the term 'institution' is replaced with the term 'facility'. The same amendment is made at section 124.

Clauses 103 -105 Issue of licence section 125

[163]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)

[164] Ibid, para 4.

‘treatment’ is replaced with ‘treatment, care or support’, and ‘institution’ is replaced with ‘facility.

Clause 106 effect of cancellation Section 131

‘or support’ is inserted after ‘care’.

Clause 107 Appointment of inspectors Section 132

‘Part’ is replaced by the word ‘chapter’.

Clause 108 - 109 Section 134

‘or support’ is inserted after ‘care’ and ‘institution’ is replaced with ‘facility’

Clauses 110 – 113 Divisions 12. 1 to 12.3 and section 136 to 137A

Divisions 12.1 to 12.3 are renumbered as parts 13.1 to 13.3. Section 136 is renumbered as Chapter 16 Meaning of reviewable decision with the word ‘division’ replaced by ‘chapter’. Sections 136 to 137A are renumbered 139CR to 139CT.

Clause 114 Notification and review of decisions Division 12.4 (as amended)

Division 12.4 (as amended) is relocated as chapter 16.

Clause 115-116 Unauthorised treatment section 138

‘treatment’ is replaced with ‘treatment, care or support’ and ‘institution’ is replaced with ‘facility.

Clause 117 Miscellaneous Division 12.5 (as amended)

Renumbered as part 13.4.

Clause 118 New Chapter 14 Mental Health Advisory Council

The Minister’s Mental Health Advisory Council currently operates. New Sections 139 to 139C provide a legislative framework for its operation.

Section 139A Mental health advisory council functions sets out the matters that the council may advise the Minister about.

Section 139B Membership of mental health advisory council requires that the membership of 5 to 7 people should where possible include a person who has or has had a mental disorder or mental illness, a carer, a person with expertise in mental health, someone with current

knowledge of the science and evidence in mental health, and someone with expertise or experience in mental health promotion, prevention and treatment care or support

Section 139C Procedures of mental health advisory council sets out that the council must meet at least quarterly and may publish its proceedings.

Clause 119 Section 140

Section 140 in the current Act is replaced by four sections.

Section 139D Approval of mental health facilities and Section 139E Approval of community care facilities address matters currently addressed by section 48 of the current Act which is omitted by this Bill. The current provisions relate only to health facilities and mental health facilities and for the purposes of sections 29(1), 36k, 37 or 41 of the current Act. The new provisions apply to the whole Act and address community care facilities as well as mental health facilities.

Section 139F Powers of entry and apprehension has brought together the powers of entry on to property and apprehension available to an authorised person when they are acting under the sections of the Act listed in Section 139F. The sections listed relate to circumstances where a person is being apprehended or detained - that is, their liberty is being restricted, for the purpose of providing involuntary treatment or to ensure the safety of the person or others under these provisions the Act. An 'authorised person' means the person authorised in each of the sections, for example the Chief Psychiatrist (or delegate) a mental health officer, ambulance paramedic or police officer.

Subsection 2 sets out that the authorised person may enter any premises to apprehend, remove or take the person to a place. Any assistance or force used must be *necessary* and *reasonable*. The person may be apprehended and removed to a mental health facility or another place where the person may be detained for treatment care or support.

Section 140 Powers of search and seizure has brought together the powers to search a person and seize property in their possession that available to an authorised person when they are acting under the sections of the Act listed in section 140. The sections listed relate to circumstances where a person is being apprehended or detained - that is,

their liberty is being restricted, for the purpose of providing involuntary treatment or to ensure the safety of the person or others under these provisions the Act. An 'authorised person' means the person authorised in each of the sections, for example the Chief Psychiatrist (or delegate) a mental health officer, ambulance paramedic or police officer.

Searches are generally categorised in terms of their level to which they intrude on personal privacy. For the purpose of the sections listed in section 140, a search is restricted to a scanning search, frisk search or ordinary search. These terms are defined in the section and are types of search which result in a a low level of intrusion. The search may only be carried out if there a reasonable grounds for believing that the person is carrying anything that would represent a danger to the authorised person or another person, or something that could assist the person to escape from the custody of the authorised person. If such a thing is found it may be seized. Seized items must be returned unless there is good reason not to as set out in subsections (4) and (5).

Article 17 of the Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation provides for the right of every person to be protected against arbitrary or unlawful interference with his privacy, family, home or correspondence as well as against unlawful attacks on his honour and reputation. The expression 'arbitrary interference' is also relevant to the protection of the right provided for in article 17. In the Committee's view the expression 'arbitrary interference' can also extend to interference provided for under the law. The introduction of the concept of arbitrariness is intended to guarantee that even interference provided for by law should be in accordance with the provisions, aims and objectives of the Covenant and should be, in any event, reasonable in the particular circumstances.[165]

The search powers are based on the powers in the *Corrections Management Act* 2007, with modifications appropriate for the exercise of search powers in a therapeutic context. The distinctions between search powers in the *Corrections Management Act* and the Mental Health

[165] The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and Reputation (Article 17) General Comment No. 16, http://www.arabhumanrights.org/publications/tbased/ccpr/right-to-privacy-comment16-88e.pdf

Amendment Bill relate to the circumstances where the power is to be used. A report on *A Human Rights Approach to Prison Management* states that:

Individual prisoners will also have to be personally searched on a regular basis to make sure that they are not carrying items which can be used in escape attempts or to injure other people or themselves, or items which are not allowed, such as illegal drugs. The intensity of such searches will vary according to circumstances [166]

The search conducted on the person should not be done at the compromise of a person's health needs. In 1993, the World Medical Association adopted a statement on body searches of prisoners which states, among other things, that the physician's obligation to provide medical care to the prisoner should not be compromised by an obligation to participate in the prison's security system. Where they have to be carried out, such searches should, therefore, be conducted by a physician other than the physician who provides medical care to the prisoner.[167]

The human rights approach to prison management report goes on to say that there should be a detailed set of procedures which staffs have to follow when carrying out personal searches. These procedures should:

- *define the circumstances in which such searches are allowed;*
- *ensure that prisoners are not humiliated by the searching process, for example, by having to be completely naked at any time;*
- *stipulate that prisoners should be searched by staff of the same gender;*
- *prohibit security staff from carrying out internal searches of a prisoner's body*. [168]

Clauses 120 to 122 Section 142 Relationship with the *Guardianship and Management of Property Act 1991*.

Amendments remove treatment for mental illness or mental disorder

[166] Andrew Coyle, *A Human Rights Approach to Prison Management*, Handbook for Prison staff, International Centre for Prison Studies, Kings College London, 2002, p 64.

[167] Statement on Body Searches of Prisoners, World Medical Association, 1993.

[168] Andrew Coyle, A Human Rights approach to Prison Management, Handbook for Prison staff, International Centre for Prison Studies, Kings College London, 2002, p 64.

(other than electroconvulsive therapy or psychosurgery) from the list of decisions which a guardian cannot make. The effect of the change is to allow a guardian to agree to this treatment on behalf of the person to whom they have been appointed guardian. See limitations on this power below.

A new note is inserted directing the reader to the *Guardianship Act* (section 70A) for the circumstances in which a guardian may consent to a person's treatment.

Clause 123 - 124 Relationship with Powers of Attorney Act Section 143(a)

This amendment proposes deleting treatment for mental illness from this subsection, which will then allow a person with the relevant Power of Attorney to consent to treatment for mental illness other than electroconvulsive therapy (ECT) or psychosurgery. A new note is inserted to direct the reader to the *Powers of Attorney Act 2006* (section 46A) for the circumstances in which the person with power of attorney may give consent to a person's treatment.

Clause 125 certain rights unaffected Section 145(a)

'treatment or care' is replaced with 'treatment, care or support'.

Clause 126 New Section 145A Provides for review of certain new provisions in the Act, after the Act has been in operation for 3 years.

Section 36V (Psychiatric Treatment Order) and Section 36ZD (Community Care Order) will be reviewed in the light of the new criterion of 'decision making capacity' which has been added to the criteria for an order. The consideration of decision making capacity as a criterion for orders is new in the ACT and has only recently begun to be included in mental health law internationally. The review will enable consideration of the impact of these provisions on the effectiveness of the *Mental Health (Treatment and Care) Act 1994* and the provision of mental health treatment, care and support, and whether further amendment may be required to improve the operation of these parts of the Act.

Sections 48ZA, 48ZB and 48ZH which provide for the new Forensic Mental Health Orders will be reviewed in the same timeframe. The review will enable consideration of whether these new provisions have improved the

delivery and oversight of mental health treatment, care and support for forensic mental health clients, and whether further amendments are needed to improve the operation of these parts of the Act.

The amendments require public submissions to be invited as part of the review (Section 145 (1)). The Minister is required to report on the review before the Act has been in operation for 4 years.

Subsection 4 requires a review of the amendment to Section 41 (5) which makes the maximum length of a second period of emergency detention from 7 days to eleven days. The maximum length of a first period of emergency detention is 3 days, so that in total it will be possible for a person to be detained under emergency detention for 14 days. The intention of the longer period is that people may be more recovered from the mental health crisis that led to their detention, and therefore more able to organise support and represent themselves at a hearing of the ACAT if a further involuntary order is being considered, or to better able to brief a legal representative. The amendment also aims to reduce the number of longer term mental health orders that may be made and subsequently prove unnecessary after a short period.

The review will enable an examination of whether the amendments are achieving the intended outcomes, and whether further amendments to the Act are required.

Clause 127 Miscellaneous Part 13 (as amneded)

Relocated as chapter 17.

Clause 128 Reviewable decisions Schedule 1 heading, reference

This clause amends the heading reference from (see div 12.4) to (see ch. 16)

Clause 129 Schedule 1, new items 1A to 1E

Clause 129 inserts new items 1A to 1E in Schedule 1 of the *Mental Health (Treatment and Care) Act* 1994, which deals with reviewable decisions. These new provisions include sections 48ZU, 48ZV, 48ZW, 48ZZQ and section 48ZZR, providing for an opportunity to apply for leave in each circumstance. In each instance, the application for leave is a reviewable decision by ACAT.

Including these sections in schedule 1 ensures that a person subject to an order may appeal a decision to refuse leave.

While a person who is a correctional patient or who is subject to a forensic mental health order may apply to ACAT for a review of their order, a refusal of leave by its nature is a part of their order. Including decisions to refusal leave in schedule 1 removes any doubt that the refusal may be subject to review.

Clauses 130 to 156 Dictionary

A number of definitions have been omitted, inserted or amended. Definitions may have been amended in one section and inserted into or omitted from another section.

New definitions are inserted for advance agreement, advance consent direction, affected person, authorised ambulance paramedic, approved community care facility, carer, child and adolescent psychiatrist, close relative or close friend, comunity based sentence, coordinating director-general, correctional patient, corrections director-general, corrections order, decision-making capacity, detainee, director-general, emergency assessment order, forensic mental health order, forensic patient, health attorney, , information sharing entity, information sharing protocol, mental disorder, nominated person, principal official visitor, private psychiatric facility, psychiatric facility, publish, registered affected person, relevant information, relevant official, relevant person, representative, transfer direction, treating team, treatment care or support, victims of crime commissioner, young detainee, young offender, young person.

Existing definitions are omitted for psychiatric institution, private psychiatric institution, offender with a mental impairment, mental dysfunction, approved health facility, applicant, application.

Definitions are amended for agreement, approved mental health facility, assessment order, community care facility, corresponding law, informed consent, inspector, interstate custodial patient, interstate non custodial order, licence, licensed premises, licensee, mental health facility, mental health professional, mental illness, proceeding, responsible person, reviewable decision, state, subject person.

Schedule 1 Other amendments

Part 1.1 Children and Young People Act 2008

1.1 Section 530(1), new definition of mental disorder

Section 9 of the *Mental Health (Treatment and Care) Act 1994*, defines mental disorder, used throughout the Act. In this Bill, there has been a shift away from the use of mental dysfunction, to a more general term of mental disorder.

1.2 Section 530(1), definition of mental dysfunction

As the phrase mental dysfunction is no longer being used by the ACT Health Directorate, or the Criminal Justice System, the definition of mental dysfunction has been omitted.

1.3 Section 530(1), definition of mental illness

The definition of mental illness has been substituted in s9A to include a condition that seriously impairs (either temporarily or permanently) the mental functioning of a person in 1 or more areas of thought, mood, volition, perception, orientation or memory. It also goes on to detail the characteristics of mental illness, including sustained or repeated irrational behaviour.

1.4 Section 863(2), example 2

This substitute in the Bill serves as a further example and clarification to section 863 (2).

Part 1.2 Corrections Management Act 2007

1.5 New section 54A

New section 54A (Transfer to mental health facility—transfer direction) deals with transfer directions in relation to transfer to mental health facilities, providing further clarification for the transfer of a detainee from a correctional centre to an approved mental health facility or approved community care facility. It provides further guidance, stating that the corrections director-general must inform the ACT Health director-general in writing of changes in the detainee's status, providing examples where this might occur.

This new section also goes on to clarify what approved community care facility and approved mental health facility refers to.

Part 1.3 Crimes Act 1900

1.6 Section 300(1), new definition of forensic mental health order

The term 'forensic mental health order', is defined in the *Mental Health (Treatment and Care) Act 1994,* and is used in the *Crimes Act 1900*, with the exact same meaning and definition.

1.7 Section 301(1)

Section 301 (Limitation on orders and detention—non-acquittals) limits the type of orders and detention the Supreme Court may make or impose where a person is dealt with under section 318(2) or section 319(2).

This amendment is consequential to the amendment to the *Mental Health (Treatment and Care) Act 1994*, section 72 (review of detention under court order). This amendment clarifies that the ACAT must review a court order as soon as possible and not later than 7 days after the court order.

1.8 Section 301(2)

Section 301 (2) in the *Crimes Act 1900 (ACT)* (Limitation on orders and detention – non acquittals) requires the Supreme Court to nominate as a best estimate a term of imprisonment, if it would have imposed a sentence of imprisonment under section 301(1). This amendment is consequential to the amendment to the *Mental Health (Treatment and Care) Act 1994*, section 72 (review of detention under court order) to ensure that the nominated term is considered by the ACAT during a review of detention.

The term 'nominated term' replaces the previously used 'limiting term'.

The nominated term also becomes an essential step to be taken by the courts, reflected in the omission of 'shall', replaced by 'must'.

1.9 New section 301(3) and (4)

As an addition to section 301 of the *Crimes Act 1900 (ACT)* (Limitation on orders and detention – non acquittals), the new subsections (3) and (4) seek to further clarify limitations on detention, requiring the courts to take into account the periods for which the person has additionally been detained in relation to the offence.

The day the nominated term takes effect is also clarified in subsection (4)

of the *Crimes Act 1900* as either the day the term is nominated or an earlier day nominated by the Supreme Court.

1.10 Section 302(1)

Section 302 of the *Crimes Act 1900 (ACT)* (Limitation on orders and detention – acquittals) limits the type of orders and detention the Supreme Court may make or impose where a person is dealt with under section 323 or section 324.

This amendment is consequential to the amendment to the *Mental Health (Treatment and Care) Act 1994*, section 72 (review of detention under court order). This amendment clarifies that the ACAT must review a court order as soon as possible and not later than 7 days after the court order.

1.1 Section 302(2)

Section 302 (2) in the *Crimes Act 1900 (ACT)* (Limitation on orders and detention – acquittals), requires the Supreme Court to nominate as a best estimate a term of imprisonment, if it would have imposed a sentence of imprisonment under section 302(1). This amendment is consequential to the amendment to the *Mental Health (Treatment and Care) Act 1994*, section 72 (review of detention under court order) to ensure that the nominated term is considered by the ACAT during a review of detention.

The term 'nominated term' replaces the previously used 'limiting term'.

The nominated term also becomes an essential step to be taken by the courts, reflected in the omission of 'shall', and is replaced by 'must'.

1.12 New section 302(3) and (4)

As an addition to section 302 of the *Crimes Act 1900 (ACT)* (Limitation on orders and detention – acquittals), new subsections (3) and (4) seek to further clarify limitations on detention, requiring the courts to take into account any additional periods for which the person has been detained in relation to the offence.

The day the nominated term takes effect is also clarified in subsection (4) of the *Crimes Act 1900 (ACT)* as either the day the term is nominated or an earlier day nominated by the Supreme Court. **1.13 Section 303**

The substituted section 303 of the *Crimes Act 1900 (ACT)*(Limitations on Supreme Court orders) applies a higher threshold to courts' decisions on detention, by stating that the courts must not order that an accused be detained for a period greater than the nominated term under section 301 or 302.

1.14 Section 304(1)

Section 304 (1) of the *Crimes Act 1900 (ACT)* (Limitation on orders and detention – dismissal of charge), limits the type of orders and detention the Magistrates Court may make or impose where a person is dealt with under section 328 or section 329.

This amendment is consequential to the amendment to the *Mental Health (Treatment and Care) Act 1994*, section 72 (review of detention under court order). This amendment clarifies that the ACAT must review a court order as soon as possible and not later than 7 days after the court order.

1.15 Section 304(2)

Section 304 (2) in the *Crimes Act 1900 (ACT)* (Limitation on orders and detention – dismissal of charges), requires the Magistrates Court to nominate as a best estimate a term of imprisonment, if it would have imposed a sentence of imprisonment under section 304(1). This amendment is consequential to the amendment to the *Mental Health (Treatment and Care) Act 1994*, section 72 (review of detention under court order) to ensure that the nominated term is considered by the ACAT during a review of detention.

The term 'nominated term' replaces the previously used 'limiting term'.

The nominated term also becomes an essential step to be taken by the courts, reflected in the omission of 'shall', and is replaced by 'must'.

1.16 New Section 304(3) and (4)

As an addition to section 304 of the *Crimes Act 1900 (ACT)* (Limitation on orders and detention – dismissal of charge), new subsections (3) and (4) seek to further clarify limitations on detention, requiring the courts to take into account any additional periods for which the person has been detained in relation to the offence.

The day the nominated term takes effect is also clarified in subsection (4) of the *Crimes Act 1900* as either the day the term is nominated or an

earlier day nominated by the Magistrates Court.

1.17 Section 305(1)

Section 305 (1) of the *Crimes Act 1900 (ACT)* (Limitation on orders and detention – Magistrates Court), limits the type of orders and detention the Magistrates Court may make or impose where a person is dealt with under section 335.

This amendment is consequential to the amendment to the *Mental Health (Treatment and Care) Act 1994*, section 72 (review of detention under court order). This amendment clarifies that the ACAT must review a court order as soon as possible and not later than 7 days after the court order.

1.18 Section 305(2)

Section 305 (2) in the *Crimes Act 1900 (ACT)* (Limitation on orders and detention – Magistrates Court), requires the Magistrates Court to nominate as a best estimate a term of imprisonment, if it would have imposed a sentence of imprisonment under section 305(1).

This amendment is consequential to the amendment to the *Mental Health (Treatment and Care) Act 1994*, section 72 (review of detention under court order) to ensure that the nominated term is considered by the ACAT during a review of detention.

The term 'nominated term' replaces the previously used 'limiting term'.

The nominated term also becomes an essential step to be taken by the courts, reflected in the omission of 'shall', and is replaced by 'must'.

1.19 New Section 305(3) and (4)

As an addition to section 305 of the *Crimes Act 1900 (ACT)* (Limitation on orders and detention – Magistrates Court), new subsections (3) and (4) seek to further clarify limitations on detention, requiring the courts to take into account any additional periods for which the person has been detained in relation to the offence.

The day the nominated term takes effect is also clarified in subsection (4) of the *Crimes Act 1900 (ACT)* as either the day the term is nominated or an earlier day nominated by the Magistrates Court. **1.20 Section 306**

The substituted section 306 of the *Crimes Act 1900 (ACT)* (Limitation on Magistrates Court orders) applies a higher threshold to courts' decisions

on detention, by stating that the courts must not order that an accused be detained for a period greater than the nominated term under section 304(2) or 305(2).**1.21 Section 309(1)(a), (b)(i) and b(ii)**

Section 309 of the *Crimes Act 1900* (Assessment whether emergency detention required), allows the Magistrates Court to order that a person needs immediate treatment or care because of a mental impairment. This section is amended to allow for the person to be taken to an 'approved mental health facility', replacing the previous specific term 'approved health facility'.

1.23 Section 309(3)

Section 309 of the *Crimes Act 1900* (Assessment whether emergency detention required) allows a police officer to arrest a person without warrant if they breach an order made under subsection 309(1). This section was amended to include the phrase 'approved mental health facility', which replaces the previously used non specific term 'approved health facility'.

1.24 Sections 309(3)(a) and 309(3)(b)

Section 309 of the *Crimes Act 1900 (ACT)* (Assessment whether emergency detention required) allows a police officer to arrest a person without warrant if they breach an order made under subsection 309(1). This section was amended to omit references to 'approved health facility' and 'approved mental health facility', leaving reference to 'facility', which links directly to the broader reference in section 309(3) to 'approved mental health facility'.

1.26 – 1.27 Section 309(4)

Section 309(4) of the *Crimes Act 1900 (ACT)* (definitions including approved health facility and approved mental health facility) is amended to delete the definition of approved health facility and also to replace the previous definition of 'approved mental health facility'. The new definition is to be read as defined in the *Mental Health (Treatment and Care) Act* 1994 dictionary.

1.28 Section 318(2)

Section 318 of the *Crimes Act 1900 (ACT)* (Non-acquittal at special hearing – non serious offence)refers to orders that the Supreme Court

considers may make during such a special hearing. This amendment is consequential to the amendment to the *Mental Health (Treatment and Care) Act 1994*, section 72 (Review of detention under court order) and clarifies that the ACAT must review a court order as soon as possible and not later than 7 days after the court order.

The amendment allows a court to order that a person be detained in custody for immediate review by the ACAT,or that the person submit to the jurisdiction of the ACAT to allow the ACAT to make a mental health order or forensic mental health order, both under the *Mental Health (Treatment and Care) Act* 1994.

This amendment is consequential to the amendment to the *Mental Health (Treatment and Care) Act 1994*, section 72 (review of detention under court order) and clarifies that the ACAT must review a court order as soon as possible and not later than 7 days after the court order.

These provisions substitute the previous references in section 319, which did not include limitation on the detention of the person.

1.29 Section 319(2) and (3)

Section 319 of the *Crimes Act 1900 (ACT)* (Non-acquittal at special hearing – serious offence), applyies if the accused is charged with a serious offence, and is not acquitted at a special hearing. Subsections (2) and (3) have been substituted to require the Supreme Court to order that the person is detained in custody for immediate review by the ACAT under s72 of the *Mental Health (Treatment and Care) Act* 1994, or order that the accused submit to the jurisdiction of ACAT to allow the ACAT to make a mental health order or a forensic mental health order under the *Mental Health (Treatment and Care) Act* 1994.

This amendment is consequential to the amendment to the *Mental Health (Treatment and Care) Act 1994*, section 72 (review of detention under court order) and clarifies that the ACAT must review a court order as soon as possible and not later than 7 days after the court order.

1.30 Section 323(3)

Section 323 of the *Crimes Act 1900 (ACT)* (Supreme Court orders following special verdict of not guilty because of mental impairment—non-serious offence) addresses action that may be taken by the Supreme

Court if a special verdict of not guilty is returned or entered for a non-serious offence. The amendment states that the Supreme Court may make orders including that the person be detained in custody for immediate review by the ACAT, or that the person submit to the jurisdiction of the ACAT to allow the ACAT to make a mental health order or a forensic mental health order, both being under the *Mental Health (Treatment and Care) Act* 1994.

This amendment is consequential to the amendment to the *Mental Health (Treatment and Care) Act 1994*, section 72 (review of detention under court order) and clarifies that the ACAT must review a court order as soon as possible and not later than 7 days after the court order.

These provisions substitute the previous references in s319, to ensure that a person detained in custody is subject to immediate review by the ACAT.

1.31 Section 324

Section 324 of the *Crimes Act 1900 (ACT)* (Supreme Court orders following special verdict of not guilty because of mental impairment—serious offence) addresses action that may be taken by the Supreme Court if a special verdict of not guilty is returned or entered for a serious offence. The amendment states that the Supreme Court may make orders including that the person be detained in custody for immediate review by the ACAT; or that after taking into account the criteria for detention in section 308 of the *Crimes Act 1900 (ACT)*, it is more appropriate that the person submit to the jurisdiction of the ACAT to allow the ACAT to make a mental health order or a forensic mental health order (under the *Mental Health (Treatment and Care) Act* 1994).

This amendment is consequential to the amendment to the *Mental Health (Treatment and Care) Act 1994*, section 72 (review of detention under court order) and clarifies that the ACAT must review a court order as soon as possible and not later than 7 days after the court order.

1.32 Section 328(3)

Section 328 of the *Crimes Act 1900* (Magistrates Court orders following finding of not guilty because of mental impairment—non-serious offence)

addresses orders that may be made under subsections 328(1) and 328(2) by the Magistrates Court if a finding of not guilty is returned or entered for a non-serious offence due to mental impairment. The amendment states that the Magistrates Court may make orders including that the person be detained in custody for immediate review by the ACAT, or that the person submit to the jurisdiction of the ACAT to allow the ACAT to make a mental health order or a forensic mental health order.

This amendment is consequential to the amendment to the *Mental Health (Treatment and Care) Act 1994*, section 72 (review of detention under court order) and clarifies that the ACAT must review a court order as soon as possible and not later than 7 days after the court order.

These provisions substitute the previous references in section 328(3), to ensure that a person detained in custody is subject to immediate review by the ACAT.

1.33 Section 329

Section 329 of the *Crimes Act 1900 (ACT)* (Magistrates Court orders following special verdict of not guilty because of mental impairment—serious offence) addresses action that may be taken by the Magistrates Court if a special verdict of not guilty is returned or entered for a serious offence. The amendment states that the Magistrates Court may make orders including that the person be detained in custody for immediate review by the ACAT; or that after taking into account the criteria for detention in section 308 of the *Crimes Act 1900 (ACT)*, it is more appropriate that the person submit to the jurisdiction of the ACAT to allow the ACAT to make a mental health order or a forensic mental health order (under the *Mental Health (Treatment and Care) Act* 1994).

This amendment is consequential to the amendment to the *Mental Health (Treatment and Care) Act 1994*, section 72 (review of detention under court order) and clarifies that the ACAT must review a court order as soon as possible and not later than 7 days after the court order.

This amendment substitutes the previous section 329 to ensure that a person detained in custody is subject to immediate review by the ACAT and clarify what criteria need to be considered by the court prior to making orders under this section.**1.34 Further amendments, mentions of mental health order**

The use of the term 'forensic mental health order' has been inserted in various places across the Act, after the use of the term 'mental health order'. This has occurred at section 315D (person found temporarily unfit to plead), section 331 (Referral to ACAT), section 334 (Powers of Magistrates Court) and section335 (Fitness to plead – Magistrates Court) of the *Crimes Act 1900 (ACT)*.

In each of these instances, it was important to note that both mental health orders, as well as forensic mental health orders were available and that there was a clear distinction between the two.

Part 1.4 Crimes (Child Sex Offenders) Regulation 2005

1.35 Section 12(1)(d)(ii)

Section 12 of the *Crimes (Child Sex Offenders) Regulation 2005* (Entities that must give offender reporting obligations notice – Act, s104 (1)) sets out the entities that must give a registrable offender a reporting obligations notice. Under the listing of these entities, s12 (1) (d)(ii) which applies to an offender released from detention under the *Mental Health (Treatment and Care) Act 1994*, is substituted to clarify references to the amended sections, as well as to include the reference to Part 7.1 (Forensic mental health orders) – the ACAT.

Part 1.5 Crimes (Sentence Administration) Act 2005

1.36 New section 321AA

The insertion of this new section in the *Crimes (Sentence Administration) Act 2005* (director-general to give information – detainees etc subject to forensic mental health orders) applies if a forensic mental health order is in force in relation to a detainee or a person serving a community based sentence.

The information given by the director-general in writing is relevant so that the Chief Psychiatrist can make an informed decision in relation to the person's treatment, care and support, including for correctional patients.

This new provision also clarifies definitions of 'community based sentence' and 'detainee'.

Part 1.6 Criminal Code 2002

1.37 Section 712A(5), definition of childrens proceeding

In relation to publishing identifying information about children's proceedings, s712A of the *Criminal Code 2002* lists people required or entitled to attend the proceeding, including the new insertion of those under forensic mental health orders or forensic community care orders in force under the *Mental Health (Treatment and Care) Act* 1994.

This new inserted provision therefore seeks to clarify that, information shared in the best interest of the child, in relation to their forensic mental health orders or forensic community care orders, by those required to, or entitled to attend the proceedings, do not commit an offence.

Part 1.7 *Guardianship and Management of Property Act 1991*

The Bill makes a number of amendments to the *Guardianship Act* to give effect to important changes in the way mental heal treatment, care or support can be provided to people without decision-making abilities.

The principle changes relate to new powers for guardians and health attorneys to consent to mental health treatment, care or support in certain circumstances.

These amendments give effect to the changes to the criteria for the making of a psychiatric treatment order clause 11, new section 36V (Psychiatric Treatment Order). New section 36V provides the amended criteria that must be met before the ACAT can make a psychiatric treatment order. Subsection 36V (2) before the ACAT may make psychiatric treatment order, the person must be lacking decision-making capacity for giving consent to the treatment, care or support *and refuses to receive treatment*, or the person has decision-making capacity to consent but refuses to consent.

Amendments in part 1.7 address the situation where a person lacks decision-making capacity to consent to treatment, care or support, but expresses a willingness to receive treatment or simply acquiesces to treatment. A guardian may be appointed to give consent to required for medical treatment involving treatment, care or support under the *Mental Health (Treatment and Care) Act 1994* in this situation.

If a guardian is not available at the time that consent for treatment, care and support is required amendments to the *Guardianship Act* allow a health attorney order to be made.

A health attorney may give consent to a treatment, care and support for up to 21 days in the first instance and for up to 8 weeks where the ACAT gives approval.

These proposed arrangements allow for the person's mental illness to be treated in the short to medium term. If the person is likely to require treatment, care and support over a longer period of time and they are not likely to regain capacity to give informed consent, the 8 week period will also allow sufficient time for the ACAT to consider an application for the appointment of a guardian to continue to make substitute decisions.

1.38 - 1.39 Sections 7(3)(e), 7(3)(ea)

These amendments reflect the changes proposed in the Bill relating to people lacking decision making ability and who are not refusing necessary treatment, care and support for a mental illness. These amendments will allow a guardian or health attorney to give consent for consent required for medical treatment involving treatment, care or support under the *Mental Health (Treatment and Care) Act 1994*.

1.40 section 19 heading

The current heading, regular review of guardians and managers, is amended to omit the word 'regular'.

1.41 – 1.42 section 19(2) and section 19(2A)

At section 19(2) the word 'review' replaces the word 'consider'. This amendment provides a positive instruction as to the need to undertake a review of any guardianship order after 3 years. This change clarifies the action to be taken.

A new section 19 (2A) is also to be inserted. Although a guardianship order is ongoing, with review at 3 years, the consent that a guardian may provide to mental health treatment care or support for a person under the *Mental Health (Treatment and Care) Act 1994* has a 6 month time limit. At the end of the 6 months the treating team for the person must advise the ACAT whether the consent is to be renewed or not. If the consent is to be renewed then this notification process achieves a review by the ACAT in line with the timing for reviews of people receiving involuntary treatment under mental health orders. This action preserves the oversight accorded to those people for the new group of people who are

to be treated under guardianship as a result of the amendments in the Bill. If the consent is not to be renewed then it is reasonable that the ACAT review the guardianship order itself. This is because if the consent is not to be renewed then the person is likely to have regained capacity to provide consent to their treatment themselves, and therefore not be eligible for the guardianship order.

Similarly, this provision allows for the ACAT to be notified if a person on a guardianship order makes an advance agreement. Only people with decision making capacity may make advance agreements. If the person has regained capacity since the making of the guardianship order such that they are able to make an advance agreement then the person is likely not to be eligible for a guardianship order.

1.43 – 1.45 Section 32A definitions of *health professional*, *medical treatment* (paragraph (a)(iii)) and *protected person*(paragraph (c))

The definition of a health professional in the *Guardianship Act* currently refers only to a doctor or a dentist. The amended definition newly defines a health professional for treatment under the *Mental Health (Treatment and Care) Act 1994* as a mental health professional as defined in that Act and for all other matters a doctor or dentist.

Subsection (iv) is inserted into the definition of medical treatment to cover treatment under this Act.

The definition of *protected person* is expanded to include a person for whom the ACAT has not appointed a guardian under the *Guardianship Act* with authority to give consent to general medical treatment, or medical treatment involving treatment, care or support under the *Mental Health (Treatment and Care) Act 1994.*

1.46 – 1.49 new sections 32D(1)(c) and 32D(4), section 32J(1)(a) and new section 32JA.

These sections provide that a health attorney may, in particular circumstances, give consent to treatment, care or support under the *Mental Health (Treatment and Care) Act 1994*. The particular amendments mean that a health professional who is considering asking a health attorney to provide consent must first take reasonable measures to

check that the person for whom consent is needed does not have an advance consent direction that would authorise the treatment.

If the person does then the health professional may rely on the authority in that advance consent direction and may not seek consent from a health attorney. Further, if the consent of a health attorney is sought it may only be relied upon for the period specified under the newly inserted section 32JA. That section outlines that the health attorney may provide consent for an initial period of 21 days with one extension (approved by the ACAT) possible for a further 8 weeks. Consent by a health attorney is a short term arrangement that recognises immediate need for treatment but is not intended to be used for long term treatment. The extension is necessary where the treating team holds the view that a person without decision making capacity is unlikely to regain it and its purpose is to provide the necessary time for an application for guardianship to be prepared, submitted and considered.

1.50 – 1.53 sections 70(1), 70(1) note and 70(2), New section 70A

The words 'mental illness' are omitted from section 70(1)(a) to limit the application of the section to prescribed treatments - electroconvulsive therapy and psychiatric surgery. The note at this subsection is also omitted because consent for treatment care and support may now be provided by guardians in certain circumstances. The amendment to section 70(2) is a more accurate reflection of the current purpose of the section.

A new section is inserted after section 70 (ACAT may consent to prescribed medical procedures) to restrict a guardian's substitute decision making function to circumstances where the protected person has no decision-making ability and both:

- expresses willingness to receive the treatment; or
- has not given advance consent to the treatment, care or support under an advance consent direction made under the *Mental Health (Treatment and Care) Act 1994* as amendment by the Bill.

Where a person is willing to receive the treatment and has provided consent to the proposed treatment care or support through the making of an advance consent direction made under the *Mental Health (Treatment*

and Care) Act 1994 as amended by the bill then the person's advance consent direction authorises the treatment and no other authority is required. In any other case, treatment, care and support for a person with no decision making ability may only be given to the person under an order under the *Mental Health (Treatment and Care) Act 1994* as amended by Bill.

There are new conditions on guardians for the giving of consent in relation to mental health treatment, care and support. The primary conditions on the exercise of consent are that the guardian may only give consent where the principal expresses willingness to receive the treatment and that the consent is limited to a maximum period of six months.

The health professional must tell the ACAT and the public advocate in writing about the consent to treatment and the period of the consent. The consent comes to an end if:

- the ACAT directs that the consent be withdrawn; or
- the person no longer meets the criteria under subsection (1). The purpose of these restrictions is to balance the need to support the best interests of protected people and to allow guardians to give consent for mental health treatment, care and support with appropriate oversight from the ACAT and the public advocate.

1.54 Dictionary, definition of *mental illness*

This amendment to the Dictionary directs the reader to section 10 of the *Mental Health (Treatment and Care) Act 1994* as amended by this bill which reflects the new definition of *mental illness*.

Part 1.8 Mental Health (Treatment and Care) Regulation 2003

1.57 – 1.63 Sections 6, 7, 9 and the Dictionary

Amendments to these sections of the Mental Health (Treatment and Care) Regulation 2003 all update the legislative references of other Australian jurisdictions mentioned in the regulations. A note is inserted with the definition of 'NSW Agreement' that reiterates the continued force and effect of the Agreement developed between the ACT and NSW.

Part 1.9 Powers of Attorney Act 2006

1.64 – 1.69 sections 12, 37, 46A and the Dictionary

This part proposes amendments to the *Powers of Attorney Act 2006* to give effect to amendments to the *Mental Health (Treatment and Care) Act 1994* in the Bill. The principal change to the *Powers of Attorney Act 2006* is to allow an attorney to consent to treatment for a mental illness (other than electroconvulsive therapy or psychiatric surgery) necessary for the principal's wellbeing.

An additional example is inserted at section 12 – meaning of health care matter – to clarify that mental health matters are now included other than electroconvulsive therapy or psychiatric surgery.

Mental illness is omitted from the list of special health care matters at section 37 although electroconvulsive therapy and psychiatric surgery remain and the definition of mental illness is also omitted as it is no longer needed here.

New conditions are inserted for attorneys who give consent in relation to mental health treatment, care and support. The primary conditions on the exercise of consent are that the attorney may only give consent where the principal lacks decision making capacity, expresses willingness to receive the treatment and has not previously provided consent though making an advance consent direction. Further, the attorney's consent is limited to a maximum period of six months.

The health professional is required to tell the ACAT and the public advocate in writing about the consent to treatment and the period of the consent. The consent comes to an end if:

- the ACAT directs that the consent be withdrawn; or
- the principle no longer meets the criteria set out at 46A(1) lacks decision making capacity but expresses an unwillingness to receive the treatment.

The purpose of these restrictions is to balance the need to support the best interests of people who make an enduring power of attorney and to allow attorneys to give consent for mental health treatment, care and support with appropriate oversight from the ACAT and the public advocate.

Part 1.10 Public Advocate Act 2005

1.70 – 1.72 Dictionary

This part making a number of amendments to important definitions used in the *Public Advocate Act 2005* consistent with amendments proposed in the Bill.

Part 1.11 Victims of Crime Act 1994

1.73 New section 11 (ba)

Section 11 of the *Victims of Crime Act 1994* deals with the commissioner's functions in connection with the administration of justice. The newly inserted subsection (ba) within this provision seeks to clarify the Commissioner's functions, by including the role to advocate for the interests of affected people under the *Mental Health (Treatment and Care) Act* 1994.

The term 'affected people' is used at various places, and is addressed expressly in Part 7.3 of the Bill.