2015

THE LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

Mental Health Bill 2015

Revised Explanatory Statement

Presented by
Simon Corbell MLA
Minister for Health

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Glossary

This Glossary is complemented by this Explanatory Statement's *2. What terminology, and ACT, Australian and international law, are key to understanding the Bill and its Explanatory Statement?*, at pages 1 to 7, inclusive.

'Amended Act': *Mental Health (Treatment and Care) Act 1994* (ACT) as it will be once amended by the *Mental Health (Treatment and Care) Amendment Act 2014* (ACT) and by Schedule 2, Part 2.1, of the Mental Health Bill 2015.

CAT: United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment <http://www.legislation.act.gov.au/updates/humanrights/humanrights.asp>.

CEDAW: United Nations Convention on the Elimination of All Forms of Discrimination Against Women <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx>.

CERD: United Nations Convention on the Elimination of All Forms of Racial Discrimination <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CERD.aspx>.

CESCR: International Covenant on Economic, Social and Cultural Rights <http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>.

CRC: United Nations Convention on the Rights of the Child <http://www.ohchr.org/en/professionalinterest/pages/crc.aspx>.

CRPD: United Nations Convention on the Rights of Persons with Disabilities <http://www2.ohchr.org/english/law/disabilities-convention.htm>.

CCPR: International Covenant on Civil and Political Rights <http://www.legislation.act.gov.au/updates/humanrights/humanrights.asp>.

'Human Rights Act': *Human Rights Act 2004* (ACT) <http://www.legislation.act.gov.au/a/2004-5/default.asp>.

'Legislation Act': *Legislation Act 2001* (ACT) <http://www.legislation.act.gov.au/a/2001-14/default.asp>.

'Mental Health Act' or 'current Act': *Mental Health (Treatment and Care) Act 1994* (ACT) <http://www.legislation.act.gov.au/a/1994-44/default.asp>.

'Mental Health Amendment Act' or 'Amendment Act': *Mental Health (Treatment and Care) Amendment Act 2014* (ACT) <http://www.legislation.act.gov.au/a/2014-51/default.asp>.

1. Introduction

1.1 This Explanatory Statement is on the Mental Health Bill 2015 ('the Bill') of the Australian Capital Territory (ACT). Apart from this segment *–1. Introduction –* the Explanatory Statement is comprised of segments:

- *2. What terminology, and ACT, Australian and international law, are key to understanding the Bill and its Explanatory Statement?*. It outlines the terms and law that most facilitate comprehension of the Bill and its Explanatory Statement.
- *3. What is the Bill about?*. It sketches the Bill's structure and the main social advances that culminated in the Bill.
- *4. What makes the Bill compatible with the* ACT Human Rights Act 1994*?*. It notes how those clauses of the Bill that limit human rights codified in the *Human Rights Act 1994* (ACT)[1] are, nonetheless, compatible with that Act.
- *5. What are the Bill clauses about?*. It summarises the meaning of each of the clauses, in the order in which they appear in the Bill.

2. What terminology, and ACT, Australian and international law, are key to understanding the Bill and its Explanatory Statement?

'Amended Act', 'section', and 'clause'

2.1 This ES uses 'amended Act' to denote the *Mental Health (Treatment and Care) Act 1994* ('the Act' or 'the current Act'), as it will be once it is amended by the *Mental Health (Treatment and Care) Amendment Act 2014* ('the Amendment Act'),[2] upon its commencement.

2.2 Clause 2 of the Bill would commence the *Mental Health Act 2015* immediately after the Amendment Act's commencement.

2.3 Bill Schedule 2, Division 2.1.2, would relocate, into the *Mental Health Act 2015*, many sections of the Act as amended by the Amendment Act and by the *Mental Health Bill 2015*. This Explanatory Statement uses 'section' to denote a relocated provision and 'clause' to denote a provision that would not be relocated into the *Mental Health Act 2015*, but would, instead, be newly created by the commencement of the *Mental Health Act 2015*.

[1] *Human Rights Act 2004* (ACT) (Human Rights Act) <http://www.legislation.act.gov.au/a/2004-5/default.asp>, accessed 25 Jan. 2015.

[2] Those sections may be read on the ACT Legislation Register: *Mental Health Treatment and Care Amendment Act 2014* <http://www.legislation.act.gov.au/a/2014-51/default.asp>, accessed 13 March 2015.

‘People with mental illness/es and/or disorder/s’

2.4 The meanings of ‘mental illness’ and ‘mental disorder’, here, are those respectively supplied by sections 10 and 9 of the Amendment Act. It can be expected that any people who receive services under the proposed *Mental Health Act 2015* would have *plural* mental illnesses *or* plural disorders; or *plural* mental illnesses *and* disorders; or *one* mental illness *and one* mental disorder; or one mental illness and *no* mental disorder or vice versa; or one mental illness and *plural* mental disorders or vice versa. The Explanatory Statement deploys the phrase ‘people with mental illness/es and/or disorder/s’ to be faithful to how any person who comes to need services under the proposed *Mental Health Act* 2015 could experience one or more of these combinations and permutations of mental illness/*es and/or* disorder/*s*.

‘Subject person’

2.5 ‘Subject person’ is used throughout the Explanatory Statement. This is because phrases like the ‘person being transferred’ and ‘person receiving the medication’ are unnecessarily cumbersome, wherever all the Explanatory Statement need indicate is that is referring to the person who is the subject, not the actor, of the action/s proposed by a Bill clause.

2.6 ‘Subject person’ is also employed in preference to ‘consumer’. Literature on health or community services often uses ‘consumer’ to describe the recipients of those services.[3] However, to say someone is a ‘consumer’ of health or community services tends to connote that they have ‘chosen’ to receive them. Consequently, it is to insensitively deny a person’s experience to call them a ‘consumer’ of services, when they are *involuntarily* receiving them on the orders of a court or tribunal, under mental health legislation.

Rights provided by ACT, Australian, and international law

2.7 This Explanatory Statement recurrently refers to human rights supplied by the ACT Human Rights Act, Australian common law, and international law. All these rights are fundamental to the interpretation of the Bill, and, should it be enacted, to the *Mental Health Act 2015*. This is so for six main reasons.

2.8 One, the Human Rights Act section 40B prohibits an ACT public authority – any ACT public body, bar the legislature or a court – acting incompatibly with a right or rights in the Act, unless it needs do so to comply with legislation that cannot be interpreted consistently with that right or rights.

[3] Sterling, E. et al (2010) ‘Integrating Wellness, Recovery, and Self-management for Mental Health Consumers’, *Community Mental Health Journal*, April 2010, vol. 46, issue 2, pp. 130-138.

2.9 Two, Australian common law holds that international human rights instruments ratified by Australia are binding throughout Australia,[4] including in the interpretation of any ACT bill or statute[5]. Those instruments are known as 'treaties'. Australia has ratified all the treaties cited in this Explanatory Statement.[6]

2.10 Three, the rights in those treaties, and other jurisdictions' and international courts' and tribunals' judgments that interpret those rights, are also applicable in the interpretation of any ACT bill or statute. This is because section 31(1) of the Human Rights Act allows 'International law, and the judgments of foreign and international courts and tribunals, relevant to a human right' to 'be considered in interpreting' that right[7].

2.11 Four, section 30 of the Human Rights Act requires that 'So far as it is possible to do so consistently with its *purpose*, a territory law must be interpreted in a way that is compatible with human rights' (emphasis added).[8]

2.12 Five, section 139 of the *Legislation Act 2001* (ACT)[9] ('the Legislation Act') dictates that that interpretation of an ACT Act that best achieves the Act's *purpose* is to be 'preferred to any other', irrespective of whether the Act expressly states its purpose.

2.13 Six, in Australian common law, it is a well-established rule of statutory interpretation that unless legislation curtails a fundamental right or freedom in 'unmistakable and unambiguous language', than it is to be interpreted as not effecting that curtailment.[10]

Bill Objects and Principles

2.14 Of all the Bill's provisions, it is its sections 5 Objects and 6 Principles that *most* manifest the Bill's *purposes*.[11]

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[4] In *Minister for Immigration and Ethnic Affairs v Ah Hin Teoh*, the High Court of Australia held that where:
…a statute or subordinate legislation is ambiguous, the courts should favour that construction which accords with Australia's obligations under a treaty or international convention to which Australia is a party, at least in those cases in which the legislation is enacted after, or in contemplation of, entry into, or ratification of, the relevant international instrument…such ratification requires the Executive to 'act in conformity' with the ratified international instrument (1995) 183 CLR 273 at 287).

[5] Australia has a single common law, not a common law for each state and territory, because: it received the common law of the United Kingdom (UK), upon the *Commonwealth of Australia Constitution Act 1900* (UK) establishing the federation of Australia on 1 January 1901 (<http://www.foundingdocs.gov.au/item-sdid-82.html>, accessed 12 March 2015); clause 73 of the Australian statute, the Commonwealth of Australia Constitution Act, establishes the High Court of Australia as the appellate court for all Australia's state and territory supreme courts (the Constitution of Australia <http://www.comlaw.gov.au/Details/C2013Q00005>, accessed 12 March 2015); authoritative case law indicates that while Australia's common law may be differentiated by state and territory courts, it is ultimately subject to the High Court of Australia's decisions (*Lipohar v The Queen* (1999) 200 CLR 485, 505-510 [43]–[57], *Commonwealth v Mewitt* (1997) 191 CLR 471, 522; *Kable v Director of Public Prosecutions (NSW)* (1996) 189 CLR 51, 112, and *John Pfeiffer Pty Ltd v Rogerson* (2000) 203 CLR 503); and the High Court ruled, in *Lange v Australian Broadcasting Corporation* (1997) 189 CLR 520, that there is a single common law throughout Australia, and not a separate common law for each state, and to support this, cited, at p. 563, footnote 259, the comments of Sir Owen Dixon, when he was the Chief Justice of the High Court, in 'The Common Law as an Ultimate Constitutional Foundation', read on 16 July 1957 at the tenth convention of the Law Council of Australia, and quoted in Judge Woinarski (ed) (1965), *Jesting Pilate and Other Papers and Addresses*, p. 205.

[6] United Nations ('UN') International Covenant on Economic, Social and Cultural Rights ('CESCR'), ratified by Australia on 10 Dec. 1975; UN International Convention on the Elimination of all Forms of Racial Discrimination ('CERD'), ratified by Australia on 30 Sept. 1975; UN International Covenant on Civil and Political Rights (CCPR), ratified 13 Aug. 1980; UN Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), ratified 28 July 1983; UN International Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), ratified 8 Aug. 1989; UN Convention on the Rights of the Child (CRC), ratified 17 Dec. 1990; and UN Convention on the Rights of Persons with Disabilities (CRPD), ratified 17 July 2008 and Australia acceded to that Convention's Optional Protocol on 21 August 2009: Commonwealth of Australia's Treaties Database <http://www.info.dfat.gov.au/Info/Treaties/treaties.nsf>, accessed 1 Jan. 2015.

[7] The Human Rights Act Dictionary, provided by section 3 of the Act, defines 'international law' as:
(a) the International Covenant on Civil and Political Rights and other human rights treaties to which Australia is a party; and
(b) general comments and views of the United Nations human rights treaty monitoring bodies; and
(c) declarations and standards adopted by the United Nations/General Assembly that are relevant to human rights.

[8] As per Schedule 2, and Note to Part 3A, of the Human Rights Act, all of that Act's rights were sourced from the CCPR, bar the Act's right to education, which was sourced from the CESCR, as the Act states at its Schedule 1, and Note to Part 3.

[9] *Legislation Act 2001* (ACT), ACT Legislation Register <http://www.legislation.act.gov.au/a/2001-14/default.asp>, accessed 25 Jan. 2015.

[10] *Nationwide News Pty Ltd v Wills* [1992] 177 CLR 1, 43 per Brennan J; *Re Bolton; ex parte Beane* (1987) HCA 12, 162 CLR 514, 523 per Brennan J; and *Coco v The Queen* (1994) 179 CLR 427, 437 per Mason CJ, Brennan, Gaudron and McHugh JJ).

[11] Should the Bill be enacted, the Objects and Principles will be relocated into the *Mental Health Act 2015*, by the commencement of its clause 149, Schedule 2, Amendment 2.33.

2.15 As the High Court of Australia made clear in *Carr v The State of Western Australia* [2007],[12] the objects of a statute can be used to resolve any uncertainties and ambiguities in its interpretation. Further, Bill section 6 dictates that its ten Principles will be 'taken into account' in 'exercising' any 'function under this Act'. Therefore, it will be incumbent on anyone exercising a power or discretion, or fulfilling a duty, under the proposed *Mental Health Act 2015*, to heed the Objects and Principles in doing so.

2.16 The Bill's Objects must be interpreted compatibly with the rights in the ACT Human Rights Act, as per that Act's section 30, described at paragraph 2.11, above. Further, interpretation of those rights may be informed by the international law relevant to them, as per Human Rights Act section 31(1), also described at paragraph 2.10, above.[13]

2.17 Many of the Bill's Objects are grounded in rights in the Human Rights Act and treaties. For instance the Bill's section 5(a) Object is to 'promote the recovery of people with a mental disorder or mental illness', which closely aligns with the Human Rights Act section 9 right to life. As that Act states, its section 9 was sourced from Article 6(1) of International Covenant on Civil and Political Rights ('CCPR').[14] The section 5(a) Object must then be interpreted compatibly with section 9 and that interpretation may be assisted by consideration of CCPR Article 6(1).

2.18 That interpretation of the Object is also assisted by two other treaty provisions that are reflected in it: namely, Article 6 of the Convention on the Rights of the Child ('CRC') and Article 10 of the Convention on the Rights of Persons with Disabilities ('CRPD'). Both declare the 'inherent right to life'.

2.19 Bill sections 6(a) to 6(i), inclusive, the first nine Principles, state a *right* of a 'person with a mental disorder or mental illness'. For instance, subsection 6(g) supplies a right 'to be given timely information to…maximise the person's contribution to decision-making about the person's assessment and treatment, care or support'.[15]

2.20 The tenth and final Principle, section 6(j), differs from the other section 6 Principles, in that it states 13 *actions* that 'should' be performed in the delivery of services to people with mental illness/es and/or disorders. For example, subparagraph (viii) of section 6(j) dictates that services will 'be provided in a way that ensures that the person is aware of the person's rights'.

2.21 Like its Objects, the Bill's Principles are grounded in rights in the Human Rights Act and treaties. For instance, sections 6(g) and (j) are steeped in, among other rights, the Human Rights Act section 16(2) freedom of expression. As that section states, it 'includes the freedom to seek, receive and impart information and ideas of all kinds'. The Human Rights Act enunciates that its subsection 16(2) is sourced from CCPR Articles 19(2) and (3). Those two Articles are also about the freedom to express and receive information and ideas.

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[12] HCA 47 (23 Oct. 2007), as per Glesson CJ, para. 5 and 7.

[13] The Human Rights Act Dictionary, provided by section 3 of the Act, defines 'international law' as:
(a) the International Covenant on Civil and Political Rights and other human rights treaties to which Australia is a party; and
(b) general comments and views of the United Nations human rights treaty monitoring bodies; and
(c) declarations and standards adopted by the United Nations/General Assembly that are relevant to human rights.

[14] It states this in Schedule 2 and the Note to Part 3A of the Human Rights Act.

[15] That international law requires such timeliness is explained at paragraph 4.34 of this Explanatory Statement.

2.22 Therefore, Bill sections 6(g) and (j) must be interpreted compatibly with the Human Rights Act section 16(2) and that interpretation may be assisted by consideration of CCPR Articles 19(2) and (3). Paragraphs (g) and (j) of the section 6 Principles also reflect the CRPD Article 21 'freedom of expression and opinion, and access to information'. Accordingly, that Article can be used to help interpret sections 6(g) and (j).

2.23 Further, they must be interpreted compatibly with the United Nations ('UN') Committee on Economic, Social and Cultural Rights in its General Comment No. 14 on the right to 'the highest attainable standard of physical and mental health'. In that General Comment, the said UN Committee states that there is a tight nexus between that right and the 'right to seek, receive and impart information and ideas concerning health issues'.[16]

2.24 The Committee describes the latter right 'to seek…' as foundational to what it characterises as the essential 'accessibility' element of the right to health, and to the freedom of expression, declared by CCPR Article 19(2).[17] This is relevant because Article 19(2) is the source of the Human Rights Act section 16(2) freedom of expression, which is implicated in, among other provisions of the Bill, its section 6(g) and (j) Principles.

2.25 As importantly, it is relevant, because:

a. UN General Comment 14 squarely falls under the Human Rights Act definition of 'international law', which, as per that Act's section 31(1), may be considered in the interpretation of any relevant right in the Act;

b. as explained in paragraphs 2.30 to 2.34, below, there is authoritative international case law that clearly states the right to health is incorporated in the right to life and the freedom from inhuman and degrading treatment and that case law squarely falls within the said Human Rights Act definition of international law; and

c. the right to life is provided by section 9 of the Act, the freedom from inhuman and degrading treatment is provided by section 10 of the Act.

2.26 Accordingly, that case law and the UN General Comment can be used to help interpret the Bill's section 6(g) and (j) Principles which section 6 mandates must, along with all the other section 6 Principles, be taken into account in the exercise of any functions under the *Mental Health Act 2015*. Indeed, that case law and General Comment may be used to assist interpretation of any rights in the Human Rights Act to which they are relevant.

2.27 As is explained throughout this Explanatory Statement, many of those rights are implicated in many of the Bill's provisions. The assistance of the said case law and General Comment may be most helpful in the interpretation of rights implicated in the many Bill provisions that would require the chief psychiatrist, care coordinator, ACT Administrative and Civil Tribunal ('ACAT') or others to communicate with a person who will receive, or is receiving assessment, treatment, care or support, under the *Mental Health Act 2015*, should the Bill be enacted.

[16] 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.
[17] ibid.

Right to the highest attainable standard of mental health

2.28 All the Bill's Objects and Principles are clearly rooted in the right to 'the highest attainable standard of physical and mental health', proclaimed by several treaties and international law cases, specified below. Consequently, that right can be relied on to aid the interpretation of all the Objects and Principles.

2.29 The UN Special Rapporteur on this right has observed that it has migrated 'from the margins to the human rights mainstream'[18].[19] It was established by Article 12 of the International Covenant on Economic, Social and Cultural Rights ('CESCR'), in 1996, and has been codified, since, in:

- **a.** Articles 5(e)(iv) and 5(d)(vii) of the International Convention on the Elimination of All Forms of Racial Discrimination ('CERD');
- **b.** Articles 11(1)(f), 12, and 14(2)(b) of the Convention on the Elimination of All Forms of Discrimination Against Women ('CEDAW');
- **c.** CRC Article 24 for all children; and
- **d.** CRC Articles 3(3), 17, 23, 25, 32 and 283 (3), 17, 23, 25, 32 and 28 for especially vulnerable groups of children.[20]

2.30 Much authoritative international case law bears out that the right to the highest attainable standard of physical and mental health is incorporated in both the right to life and the freedom from inhuman or degrading treatment.

2.31 The European Court of Human Rights has held that nation-states have violated the freedom from inhuman or degrading treatment, by failing to deliver health treatment to a patient with mental illness;[21] to an ill prisoner;[22] and to a person injured while being arrested[23].

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[18] UN Special Rapporteur on the right to the highest attainable standard of health, Hunt, P. (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, 604. The right is not only in the abovementioned treaties, it is explicitly proclaimed in many regional treaties, such as Article 16 of African Charter on Human and Peoples' Rights, Article 10 of Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, known as 'Protocol of San Salvador', and Article 11 of European Social Charter, and in over sixty national constitutions (UN 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*, P. Hunt, submitted in accordance with Commission resolution 2002/31, E/CN.4/2003/58, 13 February 2003, p.7). Under these constitutions, there has been a proliferation of case law affirming the right. In *Mariela Viceconte v Argentinian Ministry of Health and Social* Welfare, Argentina's Federal Administrative Court of Appeals found a violation of CESCR Article 12 and ordered production of a vaccine (Poder *Judicial de la Nación*, Causa no. 31.777/96, 2 June 1998). In *Campodónico de Beviacqua, Ana Carina c/ Ministerio de Salud y Acción Social – Secretaría de Programas de Salud y Banco de Drogas Neoplásicas*, Argentina's Supreme Court held that CESCR Article 12 and Argentina's Constitution required the Government to continue providing a certain drug to a child (Supreme Court of Argentina, 24 October 2000, No. 823 XXXV). In *Mendoza and others v Ministry of Public Health and the Director of the HIV-AIDS National Programme*, Ecuador's Constitutional Court ruled the right to health must be safeguarded by the State and that it is a part of the right to life (Tribunal Constitucional, 3ra. Sala, Ecuador, Resolucion No. 0749-2003-RA, 28 Jan. 2004). There is no right to health in either of Australia's two human rights bills: the ACT Human Rights Act (full citation, at footnote 1) or Victorian *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 Jan. 2014). However, this right was commonly requested, during the federal government human rights consultation in 2009 (Commonwealth of Australia (2009) *National Human Rights Consultation* <http://www.ag.gov.au/RightsAndProtections/HumanRights/TreatyBodyReporting/Pages/HumanRightsconsultationreport.aspx>, accessed 17 Jan. 2014). Further, in late 2009, the said Rapporteur toured Australia, and in 2010, recommended that the federal parliament enact an enforceable, justiciable right to health (Grover, A. (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 UN General Assembly on 3 June 2010, A/HRC/14/20/Add.4).

[19] This Explanatory Statement's explanation of the right to health equally applies to the Amendment Bill. It contained far more clauses than this Bill. Consequently, there was not the scope, in its Explanatory Statement, to comprehensively canvas this right.

[20] Full citation of all treaties, at footnote 6.

[21] *Riviere v France*, No. 33834/03 Eur. Ct. H.R. (2006).

[22] *Holomiov v Moldova*, No. 30649/05 Eur. Ct. H.R. (2006).

[23] *Hurtado v Switzerland*, No. 17549/90 Eur. Ct. H.R. (1994).

2.32 Many countries' superior courts of law have ruled that the right to life incorporates the right to health. These include the United Kingdom House of Lords,[24] the Columbian Constitutional Court[25] and the respective Supreme Courts of India,[26] Nepal,[27] Bangladesh,[28] Pakistan,[29] and Brazil[30]. For instance, in *Savage v South Essex Partnership National Health Service Foundation Trust* (2008),[31] the House of Lords decided that, pursuant to the right to life:

a. health authorities have an 'over-arching obligation to protect the lives of patients in their hospitals'.[32]

b. hospitals have an 'operational obligation' to take all reasonable steps to prevent the suicide of any patient they know, or ought to know, is at a 'real and immediate' risk of suicide and '[i]f they fail to do this…there will…be a violation of the operational obligation under article 2 [of the European Convention on Human Rights, which is that Convention's right to life][33] to protect the patient's life'.[34]

c. health authorities are obliged to have 'systems in place to provide **access to necessary health care**' and 'an **obligation actually to provide it**'[35] (emphasis added).

2.33 In *Rabone v Anor v Pennine Care National Health Service Foundation Trust* (2012), the United Kingdom Supreme Court confirmed that hospitals have an operational duty to protect a patient's health and safety, and that that duty is pursuant to the right to life. While *Savage* was about a person who suicided, after absconding from involuntary psychiatric treatment, *Rabone* was about someone who suicided shortly after a hospital discharged them from voluntary, psychiatric treatment.[36]

2.34 These international cases that in which the right to health was found in either the right to life or the freedom from inhuman and degrading treatment are applicable in the ACT. This is because:

a. section 9 of the Human Rights Act provide for the right to life and section 10 of the same Act protects against inhuman or degrading treatment.

b. the Human Rights Act states that its section 9 right to life is sourced from Article 6(1) of the CCPR treaty, a treaty Australia has ratified, and that right is also proclaimed by Articles 6 of the CRC and 10 of the CRPD, both treaties Australia has ratified.

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[24] *Savage (Respondent) v South Essex Partnership NHS Foundation Trust (Appellate)* [2008] UKHL 74 on appeal from: [2007] EWCA Civ 1375 <http://www.publications.parliament.uk/pa/ld200809/ldjudgmt/jd081210/savage-1.htm>, accessed 2 April 2015.

[25] A. Yamin and O. Parra-vera (2009) 'How Do Courts Set Health Policy? The Case of the Columbian Constitutional Court', 6 *PLoS Med* 147, 147.

[26] *Consumer Education and Research Centre v Union of India* (1995) 1 SCR 626 (SC, India); *Paschim Banga Khet Majoor Samity v State of West Bengal* (1996) 4 SCC 37 (SC, India).

[27] *Maharjan v His Majesty of Government NKP*, 2053, vol. 8, 627 (SC, Nepal).

[28] *Mohiuddin Farooque v Bangladesh* (1996) 48 DLR 438 (HC, Bangladesh).

[29] *General Secretary West Pakistan Salt Miners Labour Union, Khewra, Jhelum v Director Industries and Mineral Development, Punjab Lahore* [1994] SCMR 2061 (SC, Pakistan).

[30] Piovesan, F. (2008) 'Impact and Challenges of Social Rights in the Courts', in M. Langford (ed.) *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law*, CUP, pp.136-7.

[31] *Savage (Respondent) v South Essex Partnership NHS Foundation Trust (Appellate)* [2008] UKHL 74.

[32] ibid., per Lord Rodger, at para. 72.

[33] European Convention on Human Rights <http://www.echr.coe.int/Documents/Convention_ENG.pdf>, accessed 2 April 2015.

[34] *Savage (Respondent) v South Essex Partnership NHS Foundation Trust (Appellate)* [2008] UKHL 74, per Lord Rodger, at para. 72.

[35] ibid., per Baroness Hale, at para. 98. See also *Keenan v United Kingdom* (2001) 33 EHRR 913, para. 110.

[36] [2012] UKSC 2 (8 February 2012) https://www.supremecourt.uk/cases/uksc-2010-0140.html> accessed 25 Jan. 2014.

c. the Human Rights Act states that its section 10 freedom from inhuman or degrading treatment is sourced from CCPR Article 7 and section 10 also reflects Articles 1 to 3, inclusive, and 13 to 16, inclusive, of the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT),[37] as well as Articles 37 and 39 of the CRC and Article 15 of the CRPD, all treaties Australia has ratified.[38]

d. as noted at paragraphs 2.9 and 2.10, under Australian common law,[39] treaties that Australia has ratified are binding throughout Australia, and under the Human Rights Act, those treaties, as well as other international law, and international case law, may be used to assist with the interpretation of rights in the Human Rights Act.

3. What is this Bill about?

3.1 Most of the current Mental Health Act's provisions commenced in 1997.[40] Since then, people with mental illness/es and/or disorder/s have become less marginalised by their societies, at least throughout most of the economically developed world. Among other fields, disability rights activism,[41] community development,[42] psychology,[43] psychiatry,[44] ethics,[45] and law[46] have all become more inclusive people with mental illness/es and/or disorder/s.[47]

3.2 Accordingly, in 2006, the ACT Government launched a public review of the current Act lead by the 'Review Advisory Committee'. The Committee's membership and activities are described in the Explanatory Statement on the Mental Health (Treatment and Care) Amendment Bill 2014 (ACT) ('the Amendment Bill').[48] That Bill[49] was the first one to result from the Review. It was enacted by the Legislative Assembly for the ACT ('the Legislative Assembly'), on 30 October 2014. At that time it became the *Mental Health (Treatment and Care) Amendment Act 2014* ('the Amendment Act').

3.3 This Bill, the Mental Health Bill 2015, is the second and final bill to have

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[37] Not only has Australia ratified the CAT (see footnote 6), the Legislative Assembly also has before it the Monitoring of Places of Detention (Optional Protocol to the Convention Against Torture) Bill 2013 (ACT).

[38] Full citation of all treaties, at footnote 6.

[39] To the extent of any ambiguity, all domestic statutes should be applied as far as practicable so as to conform with Australia's obligations under international law: *Kartinyeri v Commonwealth* (1998) 195 CLR 337, 384 (Gummow and Hayne JJ) and *Jumbunna Coal Mine N/L v Victorian Coalminers' Association* (1908) 6 CLR 309, 363 (O'Connor J). This principle applies to all statutes, not just those that seek to implement Australia's treaty obligations: *Minister for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273, 287 (Mason CJ and Deane J); *Chu Kheng Lim v Minister for Immigration, Local Government and Ethnic Affairs* (1992) 176 CLR 1, 38 Brennan, Deane and Dawson JJ. 'Ambiguity' in this context is to be construed broadly: *Minister for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273, 287 (Mason CJ and Deane J). Human rights law is also a valid influence on the development and interpretation of the common law, so, therefore, any case law interpreting the enactment of this Bill: *Queensland v Mabo (No 2)* (1991) 175 CLR 1, 42 (Brennan J).

[40] Mental Health (Treatment and Care) Commencement Notice 1995 (repealed), made under section 2 of the *Mental Health (Treatment and Care) Act 1994*, <http://www.legislation.act.gov.au/cn/1995-4/default.asp>, accessed 25 Jan. 2014. The Act has been recurrently amended since it was first enacted: see its legislative history on the ACT Legislation Register <http://www.legislation.act.gov.au/a/1994-44/default.asp>, accessed 25 Jan. 2014.

[41] For instance, Rosen, A., Rosen, T. and McGorry, P. D. (2012) The human rights of people with severe and persistent mental illness: can conflicts between dominant and non-dominant paradigms be reconciled?', in M. Dudley, F. Gale & D. Silove (eds), *Mental Health and Human Rights: Vision, praxis, and Courage*, Oxford University Press, United States of America, pp.297-320.

[42] For instance, Sylvestre, J. et al (2006) 'Housing for people with serious mental illness: Challenges for system level community development', *Community Development*, vol. 37, issue 3, pp.35-45.

[43] For instance, Nelson, G., Kloose, B. and Ornelas, J. (eds) (2014) *Community Psychology and Community Mental Health: Towards Transformative Change (Advances in Community Psychology)*, Oxford University Press, Oxford, United Kingdom.

[44] For instance, Roy, A.K., Lopes, V. and Klein, R.G. (2014) 'Disruptive Mood Dysregulation Disorder: A New Diagnostic Approach to Chronic Irritability in Youth', *American Journal of Psychiatry*, vol. 171, issue 9, pp.918-924.

[45] For instance, Kelly B.D. (2015) 'Human rights in psychiatric practice: an overview for clinicians', *BJPsych Advances*, vol. 21, issue 1, January 2015, pp.54-62.

[46] In the ACT, for example, the Human Rights Act commenced on 1 July 2004, and the *Mental Health (Treatment and Care) Act 1994* (ACT) ('the Act'), commenced on 6 Feb. 1995.

[47] As noted by the then ACT Minister for Health, Ms Katy Gallagher MLA, in the Legislative Assembly debate in which the *Mental Health (Treatment and Care) Amendment Act 2014* (ACT) was passed, on 30 Oct. 2014, *Debates, Weekly Hansard, Legislative Assembly for the ACT, Eight Assembly, 30 October 2014*, p.3848 <http://www.hansard.act.gov.au/hansard/2014/pdfs/20141030.pdf>, accessed 25 Jan. 2015.

[48] Explanatory Statement for Amendment Bill: ACT Legislation Register <http://www.legislation.act.gov.au/a/2014-51/default.asp>, accessed 25 Jan. 2015.

[49] ibid.

resulted from the Review. The proposed *Mental Health Act 2015* would complete the reforms that the Review recommended,[50] by:

a. relocating, into the *Mental Health Act 2015*, sections of the *Mental Health (Treatment and Care) Act 1994* as that Act will be once amended by the Amendment Act ('the amended Act');

b. relocating, into the *Mental Health Act 2015* sections of the amended Act amended by the Bill;[51]

c. supplying provisions to the *Mental Health Act 2015* that will not be relocated as per **a.** or **b.**;

and

d. repealing the amended Act, which, in effect, will be replaced by the *Mental Health Act 2015*.

Relocations of sections

3.4 The sections that would be relocated by the commencement of the *Mental Health Act 2015*, and the Chapters of that Act into which they would be relocated, are:

a. sections 5 to 13, inclusive, into Chapter 2 (Objects and important concepts);

b. sections 14 to 32, inclusive, into Chapter 3 (Rights of people with mental disorder or mental illness);

c. sections 33 to 36, inclusive, and 36A to 36M, into Chapter 4 (Assessments);

d. sections 36N to 36ZQ, inclusive, into Chapter 5 (Mental Health Orders);

e. sections 37, 38, 38A, 40, 41, 41AA, 42 and 45 into Chapter 6 (Emergency Detention);

f. sections 48S to 48ZZH, inclusive, into Chapter 7 (Forensic mental health);

g. sections 48ZZI to 48ZZR, inclusive, into Chapter 8 (Correctional patients);

h. sections 68 to 75, inclusive, into Chapter 10 (Referrals by courts under Crimes Act and Children and Young People Act);

i. sections 76 to 87, inclusive, into Chapter 11 (ACAT procedural matters);

j. sections 112 to 122J, inclusive, into Chapter 12 (Administration);

k. sections 139 to 139C, inclusive, into Chapter 14 (Mental health advisory council);

l. sections 139CR to 139CT, inclusive, into Chapter 16 (Notification and review of decisions); and

m. sections 139D to 147, inclusive, into Chapter 17 (Miscellaneous).[52]

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[50] For more on the Review and Review Advisory Committee, see *5. Who and what informed these changes?*, in the Explanatory Statement on the Mental Health (Treatment and Care) Amendment Bill 2014: ACT Legislation Register <http://www.legislation.act.gov.au/a/2014-51/default.asp>, accessed 25 Jan. 2015.

[51] Those sections may be read on the ACT Legislation Register: *Mental Health Treatment and Care Amendment Act 2014* <http://www.legislation.act.gov.au/a/2014-51/default.asp>, accessed 13 March 2015.

[52] These relocations are provided for by proposed amendments in Bill Schedule 2. For explanation of the content of these amendments, please see *5. What are the Bill clauses about?*. Schedule 2 is provided by Bill clause 149.

3.5 Each relocated section is on the topic denoted by the title of the Act Chapter into which it would be relocated.

3.6 Some of these relocated sections will be provisions of the current Act that are *not* amended by the *Mental Health (Treatment and Care) Amendment Act 2014* ('the Amendment Act') and would *not* be amended by the *Mental Health Act 2015*. For explanation of those relocated sections, please see the Explanatory Statement on the *Mental Health (Treatment and Care) Act 1994*.[53]

3.7 There are three other kinds of relocated sections.

3.8 First, the Amendment Act's Explanatory Statement indicates which of the relocated sections will be:

a. provisions of the *Mental Health (Treatment and Care) Act 1994*, that are altogether new ones, supplied to that Act by the commencement of the Amendment Act; or

b. provisions that are already in the *Mental Health (Treatment and Care) Act 1994*, but will be amended upon the Amendment Act's commencement.

For the explanations on those two kinds of relocated sections, please see the Amendment Act's Explanatory Statement.[54]

3.9 Second, this Explanatory Statement's *5. What are the Bill clauses about?* indicates the relocated sections that would not only be supplied by the Amendment Act – as per sub-paragraphs 3.8a. and b., above – but would, *then, also* be amended by the commencement of the *Mental Health Act 2015*.

3.10 The enactment of Bill clause 2 would commence the proposed *Mental Health Act 2015* immediately *after* the Amendment Act commences. The explanation for these particular relocated sections is the combination of the explanation of those sections in the Amendment Act's Explanatory Statement and in this Explanatory Statement.

3.11 Third, *5. What are the Bill clauses about?* of this Explanatory Statement indicates which relocated sections of the amended Act will not have been produced by the Amendment Act, but will, instead, be wholly supplied by the *Mental Health Act 2015*, upon its commencement. For explanation of each of these relocated sections, please see this Explanatory Statement's *5. What are the Bill clauses about?*.

Bill provisions that are not relocated sections

3.12 Chapters 1, 6, 9, 13, 15, 18, and 40 of the proposed *Mental Health Act 2015*, would, on commencement, contain sections that would not be relocated ones.

3.13 Bill Chapter 1 proposes so-called 'preliminary' clauses of the kind that always feature in the first chapter of an ACT Bill. These clauses would:

- name the Act (clause 1);
- bring it into force immediately after the commencement of the Amendment Act (clause 2);

[53] Explanatory Statement on the Mental Health (Treatment and Care) Bill 1994 < http://www.legislation.act.gov.au/b/db_14961/default.asp>, accessed 8 Sept. 2015.
[54] Explanatory Statement on the Mental Health (Treatment and Care) Amendment Bill 2014 <http://www.legislation.act.gov.au/b/db_49554/default.asp>, accessed 8 Sept. 2015.

- state the Dictionary is part of the *Mental Health Act 2015* and locate it at the end of that Act (clause 3);
- provide that the Notes in the Act are only explanatory and not a part of the Act (clause 4); and
- indicate that other legislation on the ACT statute book applies to the Act's offences (clause 4A).

3.14 Bill Chapter 6 proposes provisions that would improve how people are dealt with in, and released from, emergency detention.

3.15 Bill Chapter 9 proposes provisions that would enhance the regulation of electroconvulsive therapy and psychiatric surgery administration, including the compulsory applications, approvals, informed consent processes for them.

3.16 Bill Chapter 13 proposes refined provisions on private psychiatric facilities, including on the licensing and inspection of them.

3.17 Bill Chapter 15 proposes improved provisions that would enable the apprehension, transfer, and mental health treatment, care and support, of:

a. people who are under certain other Australian states' and territories' warrants or orders;

b. people in other states and territories who need such treatment, care and support in the ACT; or

c. people subject to orders under ACT mental health legislation who need such treatment, care and support, in another Australian state or territory.

3.18 Bill Chapter 18 proposes the:

a. amendment of the *Mental Health (Treatment and Care) Act 1994*, as it will be upon the commencement of the Amendment Act;

b. amendment of several other Acts and several Regulations, in ways that are necessitated by how those Acts and Regulations would need to interact with the *Mental Health Act 2015*; and

c. repeal of the current Act, and all the legislative instruments that were made under it, bar the interstate agreements,[55] because new instruments can be made under the *Mental Health Act 2015*, should the Bill be enacted.

3.19 Finally, Bill Chapter 40 proposes provisions for how certain decisions made, and processes in train, under the current Act, are to be treated under the *Mental Health Act 2015*. Such transitional provisions are necessary, because the authority for the said decisions and processes flows from the current Act, and that Act would be repealed upon the commencement of the *Mental Health Act 2015*.

3.20 For an account of each of the clauses in the above named Bill Chapters, please see segment 5 of this Explanatory Statement.

[55] The preservation of the instruments that are interstate agreements, under the current Act, is provided for by Bill clause 419 (Interstate agreements notified before commencement day), in Chapter 40 (Transitional), Division 40.3.5 (Other matters), Part 40.5 (Transitional—interstate application of mental health laws). The Bill provides for saving the interstate agreements, because history shows that they take a long time to make, dependent as they are on making agreements with other jurisdictions. None of the other legislative instruments are dependent on arriving at meetings of the mind with other jurisdictions.

4. What makes the Bill compatible with the *Human Rights Act 2004*?

Human Rights Act compatibility test

4.1 This segment of the Explanatory Statement describes the kinds of clauses in the Bill that would limit rights in the Human Rights Act and how these limitations would meet the two-part test set by section 28 of the Human Rights Act.

4.2 Subsection (1) of section 28 states that laws may limit rights in that Act, provided that the limitations are reasonable and demonstrably justifiable in a free and democratic society'. Subsection (2) of section 28 mandates that assessment of whether a limitation passes this test must factor in:

1. the nature of the right affected;
2. the importance of the purpose of the limitation;
3. the nature and extent of the limitation;
4. the relationship between the limitation and its purpose;

   and
5. any less restrictive, reasonably available means to achieve the limitation's purpose.

4.3 It is vital to hold in mind the following five critical dimensions of the limitations that would be effected by those Bill provisions that would be 'rights-limiting' ones.

4.4 One, as discussed in segment 2 of this Explanatory Statement, there are statutory and common law imperatives to interpret every Bill provision as consistently as possible with: the Bill's Objects and Principles and the Human Rights Act and the human rights treaties Australia has ratified. Such interpretation lessens the nature and extent of the proposed provisions' limitations on rights, as required by the third limb of the mandatory Human Rights Act section 28(2) assessment.

4.5 Two, none of the Bill provisions would limit what is regarded in international law as the five 'absolute' rights, which is to say the five CCPR rights that international law forbids limiting.[56] Only two of those absolute rights are engaged by the Bill and, as is highlighted later in this segment, many of the Bill provisions would protect them. They are:

a. the freedom from torture and other cruel, inhuman or degrading treatment or punishment, codified in Article 7 of the CCPR and section 10 of the Human Rights Act; and

b. the right to recognition before the law, codified in Article 16 of the CCPR and section 8(1) of the Human Rights Act.

[56] The rights that are absolute are:
a. freedom from torture and other cruel, inhuman or degrading treatment or punishment, codified in CCPR Article 7 and Human Rights Act section 10;
b. freedom from slavery and servitude, codified in CCPR Articles 8(1), (2), (3)(a) and (c) and Human Rights Act section 26;
c. freedom from imprisonment for inability to fulfill a contractual obligation, codified in CCPR Article 11 and Human Rights Act section 18(8);
d. prohibition against the retrospective criminal laws, codified in CCPR Article 15 and Human Rights Act section 15(1); and
e. right to recognition before the law, codified in CCPR Article 16 and Human Rights Act section 8(1).

4.6 Three, none of the Bill provisions would limit 'non-derogable' rights, the suspension of which is prohibited by CCPR Article 4(2).[57] Indeed, as is explained later in this segment, many of the Bill provisions would, by supporting the right to health, support several of those 'non-derogable' rights, such as the right to life, codified in Article 6 of the CCPR and section 9 of the Human Rights Act, and the freedom from torture and other cruel, inhuman or degrading treatment or punishment.

4.7 As noted earlier, there is a large body of international case law that holds that the right to health is incorporated in both that right to life and the freedom from torture or cruel, inhuman and degrading treatment.

4.8 Four, all the Bill's proposed limitations on non-absolute and non-derogable rights are necessary, reasonable, and the least restrictive means reasonably available to achieve two types of timeliness that the right to health requires: namely, timely assessment of people's need for mental health and community care services, and timely delivery of these services to those who need them. That international law expressly mandates these two kinds of timeliness is explained, later in this segment, at paragraph 4.34.

Apprehension powers

4.9 Some Bill clauses would empower the apprehension of persons. Those powers would include, but are not limited to, those that would be supplied by clauses:

- **a.** 139CF (Apprehension of interstate patient in breach of interstate involuntary treatment order); and
- **b.** 139CG (Apprehension of person in breach of mental health order or forensic mental health order).

4.10 These powers would limit Human Rights Act sections 11 (Protection of the family and children); 12(a) (Privacy and reputation); 13 (Freedom of movement); 15 (Peaceful assembly and freedom of association); and 18 (Right to liberty and security of person). Those limitations are explored, in light of the Human Rights Act, later in this segment, under the heading *Reasonableness and justifiability of detention powers, etc.*.

Transfer powers

4.11 The proposed *Mental Health Act 2015* would enable the transfer of a person to another Australian state or territory, from the ACT, so that they may receive treatment, care and support in that other state or territory. The Bill would also empower transfer of a person from another state or territory, to the ACT, for the purposes of receiving mental health treatment, care and support in the ACT. The Bill clauses that would supply these powers have self-explanatory titles.

[57] These non-derogable rights are the rights to:
a. life, codified in CCPR Article 6 and Human Rights Act section 9;
b. freedom from torture or cruel, inhuman and degrading treatment or punishment and medical or scientific experimentation without consent, codified in CCPR Article 7 and Human Rights Act section 10;
c. freedom from slavery and servitude, codified in CCPR Articles 8(1), (2), (3)(a) and (c) and Human Rights Act section 26;
d. freedom from imprisonment for inability to fulfill a contractual obligation, codified in CCPR Articles 11 and Human Rights Act section 18(8);
e. prohibition against retrospective criminal laws, codified in CCPR Article 15(1) and Human Rights Act section 25;
f. right to recognition before the law, codified in CCPR Articles 16 and Human Rights Act section 8(1); and
g. freedom of thought, conscience and religion, codified in CCPR Article 18(1) and (3) and Human Rights Act section 14(1).

4.12 They are:

a. clause 139CH (Interstate transfer—person under psychiatric treatment order or community care order);

b. clause 139CI (Interstate transfer—person under forensic psychiatric treatment order or forensic community care order);

c. clause 139CJ (Transfer to interstate mental health facility—emergency detention);

d. clause 139CK (Interstate transfer—when ACT order stops applying);

e. clause 139CL (Transfer of interstate patient to approved mental health facility);

f. clause 139CM (Transfer of responsibility to provide treatment, care or support in the community for interstate patient); and

g. clause 139CN (Transfer of person apprehended in another State to approved mental health facility).

4.13 These powers would potentially limit – while at the same time, supporting – Human Rights Act sections:

a. 11 (Protection of the family and children);

b. 12(a) (Privacy and reputation);

c. 13 (Freedom of movement);

d. 15 (Peaceful assembly and freedom of association); and

e. 18 (Right to liberty and security of person).

The reasonability and justifiability of these potential limitations is addressed in the below segment heading *Reasonableness and justifiability of detention powers, etc.*.

Involuntary treatment, care and support powers

4.14 In certain narrow circumstances specified by the Bill, it would allow these limitations on a person's freedoms:

a. compulsory assessment of a person for mental illness/es and/or mental disorder/s;

b. non-optional detention of a person for the purposes of giving them mental health treatment, care and support for their mental illness/es and/or disorder/s;

c. mandatory restrictions on a person's movements, and place of residence, for the purposes of the person receiving the said treatment, care and support; and

d. involuntary mental health treatment, care and support of the person.

4.15 The Bill would allow such involuntary treatment, care and support and its antecedents, such as detention and involuntary assessment, even when the person has withheld their consent to these actions, or lacks capacity to give or withhold that consent. For instance, subclause (3) of clause 53 would permit the administration of electroconvulsive therapy (ECT) to a person who lacks the capacity to decide that they will receive ECT, provided that:

a. the ECT administration is in accordance with an ECT order or an emergency ECT order made by ACAT; and

b. the person either does not refuse or resist the ECT or they are subject to a psychiatric treatment order or forensic psychiatric treatment order.

4.16 Similarly, clause 65 would permit the ACT Supreme Court to consent to the performance of psychiatric surgery on a person, upon a doctor's application, if the Court is satisfied of all of the below:

a. the person has a mental illness; and

b. the person lacks the decision-making capacity to consent to the surgery; and

c. the person has not refused to so consent; and

d. there are grounds for believing the surgery is likely to substantially benefit the person; and

e. all alternative and reasonably available treatments have failed, or are likely to fail, to benefit the person.

4.17 These Bill powers that would enable involuntary, non-consensual assessment, treatment, care and support would engage and limit the right of a person to not be subjected to medical treatment without their free consent. That right is provided by subsection (2) of Human Rights Act section 10. Section 10 supplies that Act's protection from torture and cruel, inhuman and degrading treatment.

4.18 The Bill powers that would empower detention, and restrictions on movement and place of residence, for the purposes of giving a person involuntary treatment, care and support, would engage and limit Human Rights Act sections:

a. 11 (Protection of the family and children);

b. 12(a) (Privacy and reputation);

c. 13 (Freedom of movement);

d. 15 (Peaceful assembly and freedom of association); and

e. 18 (Right to liberty and security of person).

4.19 The reasonability and justifiability of all of these powers of detention, restrictions on movement and place of residence, and involuntary treatment, care and support, under the Human Rights Act, are discussed below.

Reasonableness and justifiability of powers

4.20 There is a large body of international human rights case law from across the world on legal powers to:

a. apprehend and remove a person within a jurisdiction, or across jurisdictions, to medically assess them for mental illness/es and/or disorder/s, because they are showing signs of needing that assessment, even though the person has withheld consent to that apprehension and removal and/or lacks the decision-making capacity to give it;

b. medically assess the person for mental illness/es and/or disorder/s, directly after apprehending and removing them for that purpose, or after they have presented to a health professional qualified to conduct the assessment, even though the person has withheld consent to that assessment and/or lacks the decision-making capacity to give it;

c. give mental health treatment, care, and support to a person, once a medical assessment establishes they currently need that, even though the person has withheld consent to it and/or they lack the decision-making capacity to give that consent; and

d. restrict the person's movements and place of residence, detain them, and forcibly medicate, confine, restrain, and seclude them, if they are the least restrictive means to afford the person mental health treatment, care and support that medical assessment of them indicates they currently need, even though the person has withheld consent to one or more of these limitations on their freedom and/or they lack the decision-making capacity to give consent to any one or more of those limitations.

4.21 This body of case law shows that so long as these powers meet the following eight provisos, they meet the test of compatibility with human rights set by section 28 of the Human Rights Act discussed at the beginning of this segment.[58] One, *all* of the powers must be exercised only with caution and care, and only:

a. if their exercise is determined necessary by a medical assessment of the person conducted in accordance with clinically accepted methods by an appropriately qualified doctor.

b. in respect of a person who is, as a result of their mental illness/es and or disorder/s, posing a serious risk to their best interests, by, for example, giving away all their money and/or jeopardising their own health and safety or the health and safety of others.

4.22 Two, powers of *apprehension and removal* of a person within, or across, jurisdictions, and powers of *emergency detention* of a person, should be exercised only to remove the person to, and detain them in, an appropriate therapeutic facility to have them medically assessed for mental illness/es and/or disorder/s soon after arrival.[59]

[58] *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; and *R (Wilkinson) v. Broadmoor Special Hospital Authority* [2002] EWCA CIV 1545.

[59] *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; and *A v. United Kingdom* (1981) 4 EHRR 188, European Court of Human Rights.

4.23 Three, powers to detain a person beyond their initial, 'emergency detention' for the purposes of assessment, powers to restrict a person's movements or place of residence to give them involuntary treatment, care or support, and powers to give them involuntary treatment, care or support, can only be exercised once appropriately qualified doctors, using clinically accepted methods, establish that:

a. the person has mental illness/es and/or disorder/s;

b. the said powers need to be exercised to give the person treatment, care and support they need on account of their mental illness/es and/or disorder/s; and

c. the least restrictive form in which, and extent to which, those powers can and should be exercised to give them that treatment, care and support.[60]

4.24 Four, powers of detention, powers of restriction on movements and place of residence, and powers of involuntary treatment, care and support, can only *continue* to be exercised in respect of a person, if appropriately qualified doctors, using clinically accepted methods, *reestablish* at *regular, short intervals*:

a. that that person *remains* in need of mental health treatment, care or support;

b. whether the powers still need to be exercised to provide that treatment, care or support to that person; and, if they do

c. the least restrictive form in which, and extent to which, the powers can and should be exercised.

4.25 Five, each person must have a right to review of these powers being exercised in respect to them, where that review is:

a. performed by a court or tribunal and a court or tribunal that is independent of the exerciser of the powers; and

b. not one that only happens on application from the person, but rather, automatically occurs at regular, short intervals, after the person's initial detention, restriction on movement or residence, and/or involuntary treatment, care or support.[61]

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

[61] 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 the Victorian Court of Appeal on 6 March 1992. The Court held that a person who had been involuntarily detained in a technically incorrect way, under mental health 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 Court had no overt recourse to international or local human rights law. Nonetheless, *In the Matter of XY* is a precedent from an Australian 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 the statutory entitlement to review states that a decision made under those provisions can be reviewed by the administrative review body.

4.26 Six, one or more of these powers can only be exercised to provide the person with assessment, treatment, care or support for mental illness/es and/or disorder/s. Further, that assessment, treatment, care or support must not be significantly substandard.[62] If it is, it may violate the protection from torture and cruel, inhuman or degrading treatment, provided by several treaties and section 10 of the Human Rights Act.[63]

4.27 Seven, the exercises of such powers must not have the object of humiliating and debasing a person. They must also not severely, adversely affect the person[64] in a manner, and to a degree, incompatible with the protection against torture and cruel, inhuman and degrading treatment.[65] In assessing whether a person is so affected, regard must be had to their particular personality and 'vulnerability and their inability…to complain coherently, or at all, about how they are being affected…'.[66]

4.28 Eight, forced transfer of a person to another jurisdiction is prohibited only where that would result in them no longer receiving life-saving treatment.[67] However, it must be remembered that the transfer powers are only for the purposes of facilitating:

a. a person from the ACT to be treated, cared for, and supported in another Australian state or territory, in which their close friends and/or relatives reside, because that would assist the person's recovery;

b. a person from another state or territory to be treated, cared for, or supported in the ACT, because their close friends and/or relatives reside in the ACT and they would assist the person's recovery; and

c. a person from the ACT to receive the specialist treatment, care, or support that they need, in another Australian state or territory, because that specialist service is available there, but not in the ACT;

d. a person from another state or territory to receive the specialist treatment, care, or support that they need in the ACT, because that specialist service is available in the ACT, but not in their state or territory.

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[62] *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; and *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.

[63] *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.

[64] *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); and *Pretty v. United Kingdom* [2002] 35 EHRR 1.

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

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

[67] *D v United Kingdom* 1997-III (ECtHR), where the European Court of Human Rights found a violation of the right to freedom from inhuman treatment was found in respect of deporting a man to his country of origin where this would have resulted in the withdrawal of treatment and a painful death and *Henao v The Netherlands* App No 13669/03 (ECtHR 24 June 2003), where the same Court held that a violation of the same right would not occur, if the person's illness had not reached an advanced stage. Also see that *Bensaid v United Kingdom* (2001) 33 EHRR 205, found no violation of rights in the European Convention on Human Rights in deporting a person with mental illness to another country. However, the judgement states at pp. 219 - 220, para. 47, that the preservation of mental stability can be regarded as a right protected by article 8, the right to respect for one's 'private and family life, his home and his correspondence', which right aligns closely with section 12(a) of the *Human Rights Act 2004* (ACT).

4.29 In so doing, the Bill's interstate transfer clauses enable increased compliance with several rights of the Human Rights Act. First, they support observance of Human Rights Act section 11 (Protection of the family and children), which that Act states is sourced from CCPR Articles 17(1) and 23.[68] Section 11 also reflects Articles 5 of CERD, 16 of CEDAW, 16 of CRC, and 23 of CRPD, which also pertain to protection of the family and children. Second, the interstate transfer clauses support observance of section 27 (Rights of minorities), which the Act states are sourced from CCPR Article 27. These rights would be relevant where the patient is from an ethnic, racial, linguisitic, or religious minority.[69]

4.30 The Human Rights Act section 11 (Protection of the family and children) and section 27 (Rights of minorities) are also embedded in the Bill section 5(e) Object to 'promote the inclusion of, and participation by, people with a mental disorder or mental illness in communities of their choice'. The interstate transfer clauses would reinforce the fulfillment of that Object, and, therefore, of the section 11 and 27 rights.

4.31 These powers of apprehension, detention, transfer, restriction, and involuntary treatment, care and support can only be legally exercised in ways that are the least restrictive of people's rights. This is because:

a. those Bill clauses that respectively supply the powers stipulate conditions for initiating usage of the powers and qualifications on how the powers are to be deployed;

b. the injunctions in the Human Rights Act, common law, and the Bill's section 6 Principles, to interpret legislation as consistently as possible with the rights in the Human Rights Act, treaties ratified by Australia, and international law created under those treaties, as explained in segment 2; and

c. the Bill's section 5(c) Object, 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', which aligns with Human Rights Act sections 9 (right to life), 10 (Protection from torture and cruel, inhuman or degrading treatment etc.), 13 (Freedom of movement), 18 (Right to liberty and security of person), and 19 (Humane treatment when deprived of liberty), as well as with the CCPR rights from which the Human Rights Act states those rights were respectively sourced and the rights in other treaties ratified by Australia that assist in the interpretation of those rights.

4.32 When, as the Bill requires, these powers, are exercised in the least restrictive ways, they expedite people's access to health and community care services. It is ethically and legally imperative for such services to be accessible, and promptly so, to people experiencing mental illness/es, if they are to enjoy the right to health. The five main reasons for this are as follows.

[68] Human Rights Act section 11 also reflects Articles 5 of CERD, 16 of CEDAW, 16 of CRC, and 23 of CRPD.

[69] Human Rights Act section 11 also reflects Article 1(1) of the Declaration on the Rights of Persons Belonging to National or Ethnic or Religious and Linguistic Minorities: UN General Assembly, *Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities*, 3 February 1992, A/RES/47/135 <http://www.ohchr.org/Documents/Publications/GuideMinoritiesDeclarationen.pdf>, accessed 14 Jan. 2015. This Declaration was adopted by General Assembly resolution 47/135 of 18 December 1992.

4.33 One, as noted at paragraphs 2.30 to 2.34, the right to health is incorporated in the right to life and freedom from inhuman and degrading treatment, which are respectively provided by sections 9 and 10 of the Human Rights Act.

4.34 Two, the UN General Comment on the right to health[70] declares that that right includes obligations to provide '*timely* and appropriate health care',[71] and, more specifically '*timely access* to basic preventive, curative, rehabilitative health services and health education'[72] (emphasis added) and that one of the right's 'essential elements' is its 'accessibility', 'in all its forms', including 'health-care facilities' and 'services'.[73] This General Comment falls within the 'international law'[74] that section 31(1) of the Human Rights Act states can be considered to aid interpretation of a right in that Act. These twin timeliness imperatives and the accessibility imperative are alluded to earlier, in this Explanatory Statement, at paragraph 4.8.

4.35 Three, there is a large body of cogent, peer-reviewed research demonstrating that a person may sustain cumulatively diminished capacities to recover from mental illness/es, if they experience long periods of their illness/es being left untreated, and that a person may experience substantially shorter periods of the illness/es, and less associated, long-term disability, if the time between the onset and treatment of the illness/es is reduced.[75]

4.36 Four, *Savage (Respondent) v South Essex Partnership NHS Foundation Trust (Appellate)* (2008), a House of Lords case about mental health services, discussed in segment 2 of this Explanatory Statement, holds that the right to life obliges health authorities to have 'systems in place to provide *access to necessary health care*' and 'an *obligation actually to provide it*'[76] (emphasis added).

4.37 Five, consequent upon the right to life, there is a positive duty to prevent death[77] and there is much robust research and case law that shows that death and prolonged, significant loss of quality of life are often direct outcomes of untreated mental illness.[78]

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[70] UN 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.

[71] *Savage (Respondent) v South Essex Partnership NHS Foundation Trust (Appellate)* [2008] UKHL 74, para. 11.

[72] UN 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. 17.

[73] *Savage (Respondent) v South Essex Partnership NHS Foundation Trust (Appellate)* [2008] UKHL 74, para. 12.

[74] The Human Rights Act Dictionary, provided by section 3 of the Act, defines 'international law' as:
(a) the International Covenant on Civil and Political Rights and other human rights treaties to which Australia is a party; and
(b) general comments and views of the United Nations human rights treaty monitoring bodies; and
(c) declarations and standards adopted by the United Nations/General Assembly that are relevant to human rights.

[75] 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.

[76] ibid., per Baroness Hale at para. 98; see also *Keenan v United Kingdom* (2001) 33 EHRR 913, para. 110.

[77] For example, the United Nations Human Rights Committee has stated that: 'the right to life has been too often narrowly interpreted. The expression 'inherent right to life' cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures': *General Comment 6, Article 6: The Right to Life* (1982), U.N. Doc. HRI/GEN/1/Rev.1 at 6 (1994). The same interpretation has been applied to the equivalent right to life provided for by the European Convention on Human Rights, in *LCB v United Kingdom* (1998) 4 BHRC 477, 456 [36], *Osman v United Kingdom* (1998) 5 BHRC 293, 321 [11], *Keenan v United Kingdom* (2001) 10 BHRC 319, 348-9 [88]-[90].

[78] See, for instance, *Hunter And New England Local Health District v Merryn Elizabeth McKenna* and *Hunter And New England Local Health District v Sheila Mary Simon & Anor* [2014] HCA 44; *Presland v Hunter Area Health Service & Anor* [2003] NSWSC 754; Bukh, J.D. et al (2013) 'The effect of prolonged duration of untreated depression on antidepressant treatment outcome', vol. 145, issue 1, *Journal of Affective Disorders*, pp. 42–48; Ghio, L. et al (2014) 'Duration of untreated illness and outcomes in unipolar depression: A systematic review and meta-analysis', volumes 152-154, *Journal of Affective Disorders*, pp. 45–51; and Melle, I. et al (2008) 'Prevention of Negative Symptom Psychopathologies in First-Episode Schizophrenia: Two-Year Effects of Reducing the Duration of Untreated Psychosis', *Archives of General Psychiatry*, vol. 65, no. 6, pp. 634-640.

Psychiatric surgery and electroconvulsive therapy clauses

4.38 The Bill also contains a number of clauses that would provide for the treatment options of ECT and psychiatric surgery. Today, any discussion of the compatibility of such powers with the ACT Human Rights Act must begin by noting that an exhaustive search of 'international law', as broadly defined by the Human Rights Act,[79] reveals that none of it criticises, let alone prohibits, psychiatric surgery or ECT administered in accordance with the relevant internationally agreed, clinical standards.[80]

4.39 Moreover, a large body of peer-reviewed research, cited later in this segment, rigorously evidences the safety and efficacy of these treatments. Accordingly, Bill powers that would allow these treatments to be given to persons who need them are extending the right to health to them.

4.40 As discussed in segment 2 of this Explanatory Statement, international case law holds that the right to life, and the freedom from inhuman and degrading treatment, each encompass the right to health, and are respectively supplied by not only the common law,[81] but also sections 9 and 10 of the Human Rights Act.

Clauses on electroconvulsive therapy and related safeguards

4.41 The ECT protocol promulgated by the Royal Australian and New Zealand College of Psychiatrists is explicitly based on the relevant, internationally agreed, clinical standards. It binds psychiatrists practicing anywhere in Australia and New Zealand.[82] In Australia, psychiatrists who are to administer ECT typically receive ECT training and it accords with the spirit and letter of the protocol.[83]

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[79] See footnote 7.

[80] For example, UN General Assembly, *Torture and other cruel, inhuman or degrading treatment or punishment : Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment*, 28 July 2008, A/63/175 <http://unispal.un.org/UNISPAL.NSF/0/707AC2611E22CE6B852574BB004F4C95>, accessed 14 Jan. 2015, in which, on p. 15, the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment objects not to ECT *per se*, but ECT deployed as torture, punishment, or in unmodified form, and, on page 14, the Special Rapporteur objects not to psychosurgery, *per se*, but its performance on a person without their 'free and informed consent'.

[81] See, for example, in *Australian Capital Territory v* JT [2009] ACTSC 105, the then Chief Justice of the ACT Supreme Court confirmed that nutrition could not be withheld from a patient who strongly objected to being fed but lacked the capacity to make this decision, as a consequence of their mental illness. His Honour held, at para. 63, that the right to humane treatment did not override the basic duty to preserve life where a patient is not capable of making his own decisions. See, also, the wide coverage of fundamental human rights in Australian common law by the 'principle of legality', as discussed in D.C. Pearce and R.D. Geddes (2006), *Statutory Interpretation in Australia,* LexisNexis, Butterworths, 6th ed, 165 [5.2]; Robin Creyke, 'The Performance of Administrative Law in Protecting Rights' cited in T. Campbell, J. Goldsworthy and A. Stone (eds) (2006), *Protecting Rights Without a Bill of Rights*, Ashgate Publishing, pp.101 and 113; Chief Justice J.J.Spigelman (2008) *Statutory Interpretation and Human Rights*, University of Queensland Press, p.23.

[82] Royal Australian and New Zealand College of Psychiatrists (2013) *Position Statement 74, Electroconvulsive Therapy (ECT) August 2013*, p.1 <https://www.ranzcp.org/Files/ranzcp-attachments/Resources/College_Statements/Position_Statements/74-Electroconvulsive-Therapy-GC2012-3.aspx>, accessed 14 Jan. 2015.

[83] See directly under the heading 'ECT Practice' in Leiknes, K.A., Jarosh-von Schweder, L. and Hoie, B. (2012) 'Contemporary use and practice of electroconvulsive therapy worldwide', *Brain Behaviour*, May, vol. 2, no. 3, pp.283–344 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3381633/>, accessed 14 Jan. 2014.

4.42 The few criticisms regarding ECT published by the UN, or other authoritative commentators on human rights abuses, are about two scenarios: one, the conversion of ECT into an instrument of torture or punishment[84] and, two, the application of ECT in an 'unmodified' form[85]. ECT as torture and 'unmodified' ECT are unequivocally alien to the relevant, internationally agreed clinical standards on ECT.

4.43 'Unmodified' ECT is applied to therapeutically treat someone,[86] not torture them, but is administered without the anaesthesia and muscle relaxants that the international clinical standards mandate.[87] Unmodified ECT, and ECT as torture, tend to be practised in economically developing places of the world, and are not practised in the ACT.[88]

4.44 Nonetheless, the Bill contains many controls for prevention of such abusive uses of ECT and of accidental ECT administration that is not authorised by the proposed Act. These clauses include, but are not limited to:

a. clause 50, which requires a particular form of consent for ECT;

b. clause 55B(1), which states that it is an offence for anyone, other than a doctor, to administer ECT to a person, and that the maximum penalty for that offence is 100 penalty units, imprisonment for 1 year, or both;

c. clause 55B(2), which makes it an offence for a doctor to administer ECT contrary to the requirements of Division 9.2.1 (Administration of electroconvulsive therapy), with a maximum penalty of 50 penalty units, imprisonment for six months, or both;

d. clause 55C(1), which dictates an application to make a person subject to an ECT order – whether they are an adult or under 18 years of age – can only be made by a chief psychiatrist or doctor who believes, on reasonable grounds, that ACAT could subject that person to the order, under the law;

e. clause 55C(3), which stipulates that an application for an ECT order for a person under 18 years of age must have the support of a child and adolescent psychiatrist, who is a different person to the applicant for the order, even if that applicant is also a child and adolescent psychiatrist;

f. clause 55J(a), which declares that when ACAT is deciding whether or not to make the person the subject of an ECT order, ACAT will take into account the person's views and wishes, so far as they can be discovered, including from any advance agreement and consent direction;

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[84] E/CN.4/1986/15, para. 119 and Amnesty International, *Arming the Torturers, Electro-Shock Torture and the Spread of Stun Technology,* 1997, AI Index ACT 40/001/1997. See also CAT/C/75, para. 143 and Human Rights Committee, views on communication No. 11/1977, *Grille Motta v. Uruguay*, adopted on 29 July 1980 (CCPR/C/10/D/11/1977) and communication No. 366/1989, *Kanana v. Zaire*, adopted on 2 November 1993 (CCPR/C/49/D/366/1989).

[85] For instance, UN General Assembly, Nowack, M. (2008) *Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment,* cites CPT/Inf (2006) 30, paras. 58-68 and CPT/Inf (99) 2, paras. 178-182, reports the European Committee for the Prevention of Torture has documented the administration of 'electro-convulsion therapy', in its unmodified form, in psychiatric establishments in Turkey, showing that 'Out of the total of 15,877 'electro-convulsion therapy' sessions administered at Bakirkoy, only 512 (3.2 per cent) were modified'.

[86] ibid, p.15.

[87] See, for instance, James, B. et al (2009) 'Unmodified electroconvulsive therapy: changes in knowledge and attitudes of Nigerian medical students', *African Health Sciences*, December 2009, vol. 9, no. 4, pp.279–283. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3074393/> and Rajkumar, R.P. (2014) 'Unmodified electroconvulsive therapy: a false dilemma', *Indian Journal of Medical Ethics*, April 2014, vol. 11, no. 2, pp.89-93 <http://ijme.in/index.php/ijme/article/view/1933/4199>, both accessed 14 January 2014.

[88] For evidence of unmodified ECT uses, see, for instance, Leiknes, K.A., Jarosh-von Schweder, L. and Hoie, B. (2012) (full citation at footnote 83); James, B. et al (2010) 'Unmodified Electroconvulsive Therapy: The Perspective of Patients From a Developing Country', *Journal of ECT*, September 2010, vol, 26, issue 3, pp 218-222 >, accessed 14 Jan. 2015. For uses of EC as torture, see E/CN.4/1986/15, para. 119 and CAT/C/75, para. 143 and Human Rights Committee, Views on Communication No. 11/1977, *Grille Motta v. Uruguay*, adopted on 29 July 1980 (CCPR/C/10/D/11/1977) and Communication No. 366/1989, *Kanana v. Zaire*, adopted on 2 November 1993 (CCPR/C/49/D/366/1989).

g. the stringent requirements of when ECT may, and may not, be administered to young people of 12 years old and more, that would be provided by clauses 54 (Young person with decision-making capacity) and 55 (Young person without decision-making capacity); and

h. section 51(3), which would ban the administration of ECT to people under 12 years of age.

4.45 The Review Advisory Committee decided that the ban, mentioned at **h.**, was prudent, even though ECT is rarely[89] administered to pre-adolescent children in Australia, because of the dearth of research evidence recommending ECT for children who have mental illness/es treatable by ECT and are under 12 years of age.[90]

4.46 However, the Committee resolved that the Act should allow ECT to be a treatment option for people over 12 years old. They determined this, because there are many contemporary, methodologically rigorous, and peer reviewed studies evidencing that:

a. ECT is safe, effective, and even life-saving, for people with clinical depression, mania, or psychosis;[91]

b. some people are unable to tolerate the medications, or medication dosages, used to treat depression, mania, or psychosis, and their symptoms cannot be relieved by psychotherapy alone;[92]

c. some people have depression, mania, and psychosis that proves unresponsive to both the medications and psychotherapy;[93] and

d. some of these people have life-threatening symptoms that direly need the rapid, significant alleviation that practitioners[94] and recipients of ECT, say it affords[95].

4.47 None of this is to deny that it is well documented that ECT has some adverse side effects on some people.[96] However, it is to suggest that ECT is often a life-saving treatment. Accordingly, the right to life, provided by section 9 of the Human Rights Act, is bolstered by the Bill clauses that regulate ECT.

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[89] Royal Australian and New Zealand College of Psychiatrists (2013) *Position Statement 74 Electroconvulsive Therapy (ECT)*, August, p. 2 < https://www.ranzcp.org/getattachment/Publications/Statements-Guidelines/PS-74-PPP-Electroconvulsive-Therapy.pdf.aspx>, accessed 15 March 2014.

[90] See, for example, Hazell, P. (2011) 'Depression in children and adolescents', based on systematic search of July 2011, on 'BJM Best Practice' webpage <http://bestpractice.bmj.com/best-practice/evidence/intervention/1008/0/sr-1008-i3.html>, accessed 15 March 2014.

[91] 'Chapter 9: Electroconvulsive therapy', in Q. Ashton Acton (ed.) (2013) *Issues in Clinical Psychology, Psychiatry, and Counseling: 2013 Edition*, Scholarly Editons, Atlanta, Georgia, United States of America; Dunne, R.A., McLoughlin, D.M. (2012) 'Systematic review and meta-analysis of bifrontal electroconvulsive therapy versus bilateral and unilateral electroconvulsive therapy in depression', *World Journal of Biological Psychiatry*, vol. 13, no. 4, pp.248-258; Kellner, C.H. et al (2006) 'Continuation electroconvulsive therapy vs pharmacotherapy for relapse prevention in major depression: a multi-site study from the Consortium for Research in Electroconvulsive Therapy (CORE)', *Archives of General Psychiatry*, vol. 63, no. 12, pp.1337–44.

[92] Frederikse, M., Petrides, G., and Kellner, C. (2006) 'Continuation and maintenance electroconvulsive therapy for the treatment of depressive illness: a response to the National Institute for Clinical Excellence report', *The Journal of ECT*, vol. 22, no. 1, pp.13–17; Royal Australian and New Zealand College of Psychiatrists (2013) *Position Statement 74 Electroconvulsive Therapy (ECT)*, August; Greenhalgh, J. et al (2005) 'Clinical and cost-effectiveness of electroconvulsive therapy for depressive illness, schizophrenia, catatonia and mania: systematic reviews and economic modelling studies', *Health Technology Assessment*, vol. 9, no. 9, pp.1-156.

[93] ibid.

[94] Royal Australian and New Zealand College of Psychiatrists (2013) *Position Statement 74 Electroconvulsive Therapy (ECT)*, August.

[95] Rose, D. et al (2003) 'Patients' perspectives on electroconvulsive therapy: systematic review', *British Medical Journal*, 326, pp. 1363-5; Behrman, A. (2003). *Electroboy: A Memoir of Mania*. Random House, New York, USA Hartmann, C.E. (2002) 'Personal Accounts: Life As Death: Hope Regained with ECT', *Psychiatric Services*, vol. 53, no. 4, pp. 413–4; Callard, B. (2010) *Unbroken*, Hodder & Stoughton, London, United Kingdom; Dukakis, K. and Tye, L. (2007), *Shock: The Healing Power of Electroconvulsive Therapy*, Avery Trade, New York, USA; Fisher, C. (2008) *Wishful Drinking*, Simon & Schuster, New York, New York, United States of America; Fisher, C. (2011) *Shockaholic*, Simon & Schuster, New York, USA; Manning, M. (1996) *Undercurrents: A Therapist's Reckoning with Her Own Depression*, HarperCollins, New York, USA.

[96] Rajagapol, R. et al (2012) 'Knowledge, experience & attitudes concerning electroconvulsive therapy among patients and their relatives', *Indian Journal of Medical Research*, vol. 135, no. 2, pp.201–210; Cristancho, M.A. et al. (2008) 'Uncommon but serious complications associated with electroconvulsive therapy: recognition and management for the clinician', *Current psychiatry reports*, vol. 10, no. 6, pp.474–80.

Clauses on psychiatric surgery and related safeguards

4.48 The other treatment that would be provided for by the proposed *Mental Health Act 2015* is psychiatric surgery.

4.49 Until the 1980s, psychiatric surgery was sometimes misused in Australia.[97] However, since then, a large body of peer-reviewed research has shown that the more contemporary psychiatric surgery techniques are safe and effectively alleviate symptoms of certain mental illness/es and/or disorder/s, where other less intrusive treatments have failed.[98]

4.50 At this stage in history, psychiatrists in Australia rarely treat people by way of psychiatric surgery.[99] Nevertheless, the Bill contains many controls for prevention of any abuses of it or any accidental performances of it without informed consent. These include, but are not limited to:

a. clause 50, which requires a particular form of consent for psychiatric surgery.

b. clause 60, which states that a doctor commits an offence with a maximum penalty of 100 penalty units, imprisonment for one year, or both, if they perform psychiatric surgery on a person and the doctor has no approval to do so from the chief psychiatrist, or the doctor has been told that the person refuses to have the surgery.

c. clause 61, which compels a doctor who proposes to perform psychiatric surgery on a person to apply to the chief psychiatrist for approval to perform it and requires that application to be in writing, and to include a copy of the consent of the person or of an order of the ACT Supreme Court that supplies consent for that person.

d. clause 65, which forbids that Court from supplying that consent, unless four conditions obtain: one, the consent is for a person with a mental illness; two, the person lacks the decision-making capacity to consent to the surgery, and has not refused that consent; three, there are grounds for believing that the surgery is likely to substantially benefit the person; and, four, all reasonably available, alternative treatments have failed, or are likely to fail.

e. clause 66(3), which provides for a maximum penalty of 50 penalty units, imprisonment for six months, or both, for a person failing to tell the chief psychiatrist that someone has said they refuse to have psychiatric surgery, even if they or the Court previously consented to it.

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[97] White, R. (2011) 'The Banning of Psychosurgery in NSW', *Australasian Psychiatry*, April 2011, vol. 19, no. 2, p.179 <http://m.apy.sagepub.com/content/19/2/179.2.extract>, accessed 1 March 2015 and its references to White, R. and Williams, S. (2009) 'Amygdaloid neurosurgery for aggressive behaviour, Sydney, 1967–1977: chronological narrative', *Australasian Psychiatry*, 2009, vol. 17, no. 5, pp. 405-409 and White, R. and Williams, S. (2009) 'Amygdaloid neurosurgery for aggressive behaviour, Sydney, 1967–1977: societal, scientific, ethical and other factors', *Australasian Psychiatry*, vol. 17, no. 5, pp.410-416.

[98] See, for instance, Chapter 8, section 8.4, of National Collaborating Centre for Mental Health (United Kingdom) (2006) *Obsessive-Compulsive Disorder: Core Interventions in the Treatment of Obsessive-Compulsive Disorder and Body Dysmorphic Disorder, NICE Clinical Guidelines*, No. 31, British Psychological Society, Leicester, United Kingdom <http://www.ncbi.nlm.nih.gov/books/NBK56463/>; Matthews, K. and Eljamel, M.S. (2003) 'Status of neurosurgery for mental disorder in Scotland: Selective literature review and overview of current clinical activity', *The British Journal of Psychiatry* 182: pp. 404-411 <http://m.bjp.rcpsych.org/content/182/5/404.full>; Nuttin, B. et al (2013) 'Consensus on guidelines for stereotactic neurosurgery for psychiatric disorders', *Journal of Neurology, Neurosurgery and Psychiatry* <http://m.jnnp.bmj.com/content/early/2014/01/20/jnnp-2013-306580.full>. All accessed 1 March 2015.

[99] Royal Australian and New Zealand College of Psychiatrists (2009) Position Statement 29 Neurosurgery for mental disorders, October <https://www.ranzcp.org/files/resources/college_statements/position_statements/ps29- pdf.aspx>; Sachdev, P.S. and Chen, X. (2009) 'Neurosurgical treatment of mood disorders: traditional psychosurgery and the advent of deep brain stimulation', Current Opinion in Psychiatry, vol. 22, no. 1, pp. 25-31 <http://www.pubfacts.com/detail/19122531/Neurosurgical-treatment-of-mood-disorders-traditional-psychosurgery-and-the-advent-of-deep-brain-sti>, Hay, P.J. and Sachdev, P.S. (1992) The present status of psychosurgery in Australia and New Zealand', Medical Journal of Australia, vol. 157, no. 1, pp. 17-19 <http://www.ncbi.nlm.nih.gov/pubmed/1640884>, and Hay, P.J. and Sachdev, P.S. (1992) The present status of psychosurgery in Australia and New Zealand', Medical Journal of Australia, vol. 157, no. 1, pp. 17-19 <http://www.ncbi.nlm.nih.gov/pubmed/1640884>, all accessed 10 August 2015; and Sachdev, P.S. (2011) 'Chapter 17: The paradox of psychosurgery to treat mental disorders', in Kapur, N. (ed.) The Paradoxical Brain, Cambridge University Press, Melbourne, p.389.

4.51 There are three main reasons it is appropriate to have the Supreme Court determine whether it should supply consent to psychiatric surgery for a person, where the person has not refused the surgery, but lacks the decision-making capacity to consent to it. First, as was recently put by an Australian lawyer and forensic psychiatrist,[100] and psychiatrist and lecturer in psychiatry, ethics and law:[101] 'autonomy is lost where decision-making capacity is lacking and, if this is not recognised, individuals may be deprived of necessary treatment'.[102]

4.52 Second, while many of today's psychiatric surgery techniques do not involve producing irreversible lesions in the brain,[103] some do.[104] Third, psychiatric surgery is rarely performed in Australia.[105]

4.53 Four dimensions of the ACT Supreme Court's practise must be recalled in response to any questions about whether a Bill should propose vesting the Supreme Court with a power to consider psychiatric surgery matters given the Court 'usually would comprise a single Supreme Court judge—which will not have any relevant expertise to make the relevant professional medical judgements'[106] and there is 'no provision in the Supreme Court Act for the appointment of assessors'[107].

4.54 First, Rule 1530(3) of the Court Procedures Rules 2006, made under section 7 of the *Court Procedures Act 2004*, states that 'Assessors may be appointed as the court directs' and such appointments can readily occur, because Rule 1530(4) makes clear that the 'Legislation Act, part 19.3 (Appointments) does not apply to an appointment under' Rule 1530(3).

4.55 Under Rule 4(1) of the *Court Procedures Rules 2006*, 'Unless a territory law otherwise provides' all the Court Procedures Rules 'apply to all proceedings in the Supreme Court…other than proceedings under the Domestic Violence and Protection Orders Act 2001 and the Domestic Violence and Protection Orders Act 2008'. There is no provision in any part of the ACT statute book that disapplies Rule 1530(3) from Supreme Court proceedings.

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[100] Kerri Eagle, LLB(Hons), LLM, FRANZCP, Forensic Psychiatrist, Justice and Forensic Mental Health Network, Sydney, NSW.

[101] Christopher J Ryan, MB BS, MHL, FRANZCP, Senior Clinical Lecturer, Discipline of Psychiatry and Centre for Values, Ethics and the Law in Medicine, University of Sydney, Sydney, NSW.

[102] Eagle, K. and Ryan, C.J. (2014) 'Potentially incapable patients objecting to treatment: doctors' powers and duties', *Medical Journal of Australia*, vol. 200, no. 6, pp. 352-354.

[103] See discussion of non-ablative neurosurgery, for example, in Chapter 8, section 8.4, of National Collaborating Centre for Mental Health (United Kingdom) (2006) *Obsessive-Compulsive Disorder: Core Interventions in the Treatment of Obsessive- Compulsive Disorder and Body Dysmorphic Disorder, NICE Clinical Guidelines*, No. 31, British Psychological Society, Leicester, United Kingdom <http://www.ncbi.nlm.nih.gov/books/NBK56463/> and Nuttin, B. et al (2013) 'Consensus on guidelines for stereotactic neurosurgery for psychiatric disorders', *Journal of Neurology, Neurosurgery and Psychiatry Online First,* doi:10.1136/jnnp-2013-306580 <http://m.jnnp.bmj.com/content/early/2014/01/20/jnnp-2013-306580.full>, both accessed 10 August 2015.

[104] See discussion of ablative neurosurgery, for example, in the Royal Australian and New Zealand College of Psychiatrists (2009) *Position Statement 29 Neurosurgery for mental disorders*, October <https://www.ranzcp.org/Files/Resources/College_Statements/Position_Statements/ps29- pdf.aspx> and in Matthews, K. and Eljamel, M.S. (2003) 'Status of neurosurgery for mental disorder in Scotland: Selective literature review and overview of current clinical activity', *The British Journal of Psychiatry*, vol. 182, pp. 404-411 <http://m.bjp.rcpsych.org/content/182/5/404.full>, both accessed 10 August 2015.

[105] See footnote 99.

[106] Legislative Assembly for the ACT Standing Committee on Justice and Community Safety (Legislative Scrutiny role), Scrutiny Report 34, p.11 < http://www.parliament.act.gov.au/__data/assets/pdf_file/0010/753976/Report-34a.pdf>, accessed 10 August 2015.

[107] ibid.

4.56 Second, the Court has extensive practice in considering medical evidence of the same, and very similar, kinds that would be presented in proceedings on applications for orders of consent for people who are candidates for psychiatric surgery. For instance, the Court not infrequently deliberates on evidence about psychiatric illnesses and treatments other than psychiatric surgery for people who are subjects of, or are proposed subjects of, orders under the *Mental Health (Treatment and Care) Act 1994*[108] and/or *Guardianship and Management of Property Act 1991* (ACT)[109].

4.57 The Supreme Court also makes judgements based on medical evidence of people's psychiatric illnesses, to determine sentences for criminal convictions,[110] order awards of compensation for criminal injuries, [111] and make findings that a person is:

a. unable to give evidence in criminal prosecution proceedings without an unacceptable risk of serious mental harm to themselves;[112]

b. not guilty by reason of mental impairment;[113] and

c. unfit to plead by reason of mental impairment[114].

4.58 Finally, the Court forms its own view of, among other things, medical evidence on people's mental illnesses, when making decisions under the *Workers Compensation Act 1951* (ACT), and the law of torts,[115] motor accident insurance,[116] and probate[117].

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[108] See, for example, *C v Chief Psychiatrist and anor* [2011] ACTSC 195 (5 December 2011) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2011/195.html?stem=0&synonyms=0&query=psychiatric> and *Australian Capital Territory v JT* [2009] ACTSC 105 (28 August 2008) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2009/105.html?stem=0&synonyms=0&query=guardianship%20AND%20psychiatric>, both accessed 10 August 2015.

[109] See, for example, *Jr v Mental Health ACT* [2006] ACTSC *10* (2 February 2006) <http://www.austlii.edu.au/au/cases/act/ACTSC/2006/10.html>, *A v. Guardianship and Management of Property Tribunal* [1999] ACTSC 77 (16 July 1999) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/1999/77.html?stem=0&synonyms=0&query=guardianship%20AND%20psychiatric>, accessed 10 August 2015.

[110] See, for example, *Znotins v Harvey* [2015] ACTSC 241 (24 August 2015) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2015/241.html?stem=0&synonyms=0&query=guardianship%20AND%20psychiatric>, *R v Dunne* [2014] ACTSC 199 (3 July 2014), para. 13 to 33 <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2014/199.html?stem=0&synonyms=0&query=psychiatric>, and *R v Goonerage* [2005] ACTSC 96 (30 September 2005) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2005/96.html?stem=0&synonyms=0&query=%22victim%20impact%20statement%22%20and%20psychiatric>, all accessed 10 August 2015.

[111] See, for example, *In the matter of an application under the Criminal Injuries Compensation Act 1983* [2004] ACTSC 60 (9 July 2004) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2004/60.html?stem=0&synonyms=0&query=victims%20and%20of%20and%20crime%20and%20financial%20and%20assistance%20and%20act%20and%201983%20and%20psychiatric>, accessed 10 August 2015.

[112] See, for example, *R v Nona* [2015] ACTSC 175 (13 July 2015) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2015/175.html?stem=0&synonyms=0&query=criminal%20and%20compensation%20and%20psychiatric>, accessed 10 August 2015.

[113] See, for example, *R v Barker* [2014] ACTSC 153 (27 June 2014) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2014/153.html?stem=0&synonyms=0&query=criminal%20and%20injuries%20and%20psychiatric>, *R v McGuckin* [2014] ACTSC 242 (18 September 2014) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2014/242.html?stem=0&synonyms=0&query=criminal%20and%20injuries%20and%20psychiatric>, and *R v Alexander Marcel Andre Sebastian Barker Bailiff* [2011] ACTSC 214 (30 November 2011) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2011/214.html?stem=0&synonyms=0&query=guardianship%20AND%20psychiatric> all accessed 10 August 2015

[114] See, for example, *R v JG* [2014] ACTSC 120 (7 May 2014) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2014/120.html?stem=0&synonyms=0&query=unfit%20and%20to%20and%20plead >, *R v Dunn* [2011] ACTSC 84 (12 May 2011) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2011/84.html?stem=0&synonyms=0&query=guardianship%20AND%20psychiatric>, and *R v Monaghan (No 2)* [2011] ACTSC 62 (14 April 2011) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2011/62.html?stem=0&synonyms=0&query=guardianship%20AND%20psychiatric> all accessed 10 August 2015.

[115] See, for example, *Blunden v Commonwealth Of Australia* [2014] ACTSC 123 (2 June 2014) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2014/123.html?stem=0&synonyms=0&query=psychiatric>, accessed 10 August 2015.

[116] See, for example, *Branka Matijevic v Darryl John Taylor and Insurance Australia t/as NRMA Insurance* [2013] ACTSC 192 (23 September 2013) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2013/192.html?stem=0&synonyms=0&query=psychiatric>, accessed 10 August 2015.

[117] See, for example, *In the Matter of the Estate of Jones (Deceased) and in the Matter of the Public Trustee of the Australian Capital Territory* [2014] ACTSC 200 (20 August 2014)

4.59 Third, the Supreme Court may not only hear expert opinion, as is expressly envisaged by sections 79(1) and 177 of the *Evidence Act 2011* (ACT), it also routinely hears such opinion on people's psychiatric diagnoses and prognoses.[118]

4.60 Fourth and finally, a Supreme Court judge may order, under section 13 of the *Supreme Court Act 1933*, that jurisdiction in a matter be exercised by the Full Court of the Supreme Court and judges are well aware of that power to make orders, not least because members of the public not infrequently make applications for them.[119] Moreover, it is also not uncommon for those judges to make such orders[120].

Other safeguards on treatment powers

4.61 Some of the Bill's clauses stipulate that, in certain circumstances, the person with mental illness/es and/or disorders will be consulted or given information by certain people, and that certain people will record whether they consulted with the person, and if not, why not. For instance:

a. clause 55D compels ACAT to consult with specified people when it is determining whether to make a person subject to an ECT order; and

b. clause 62(2) dictates that a specified committee will consult with specified people about a doctor's application to perform psychiatric surgery on a person.

<http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2014/200.html?stem=0&synonyms=0&query=testamentary%20and%20capacity> and *In the Estate of McFadyen* [2015] ACTSC 219 (31 August 2015) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2015/219.html?stem=0&synonyms=0&query=guardianship%20AND%20psychiatric>, both accessed 10 August 2015.

[118] See, for example, *Singh v Cooper and Insurance Australia Limited* [2015] ACTSC 243 (21 August 2015) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2015/243.html?stem=0&synonyms=0&query=expert%20AND%20psychiatric>, *Jausnik v Nominal Defendant (No 3)* [2015] ACTSC 131 (15 May 2015) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2015/131.html?stem=0&synonyms=0&query=psychiatrist%20AND%20expert%20NEAR%20appointed>, *R v Wrigley* [2015] ACTSC 114 (11 May 2015) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2015/114.html?stem=0&synonyms=0&query=expert%20AND%20psychiatric>, *Plaintiff AB v Trustees of the Marist Brothers & Ors* [2014] ACTSC 381 (28 November 2014) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2014/381.html?stem=0&synonyms=0&query=expert%20AND%20psychiatric>, all accessed 10 August 2015.

[119] See, for example, *Legal Practitioner v Council of the Law Society of the ACT* [2014] ACTSC 256 (29 July 2014), para. 9 to 19 <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2014/256.html?stem=0&synonyms=0&query=act%20consol_act%20sca1933183%20s13>, *In the matter of an application by Knight under the* Criminal Injuries Compensation Act 1983 (ACT) [2014] ACTSC 337, para. 67 (19 December 2014) <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2014/337.html?stem=0&synonyms=0&query=act%20consol_act%20sca1933183%20s13>, all accessed 10 August 2015.

[120] See, for example, *Cooper v Hill* [2014] ACTSC 94 (16 May 2014), para. 10 <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2014/94.html?stem=0&synonyms=0&query=act%20consol_act%20sca1933183%20s13#disp2>, *Brewer & Anor v R* [2004] ACTSC 71 (23 August 2004), para. 2 <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2004/71.html?stem=0&synonyms=0&query=act%20consol_act%20sca1933183%20s13#disp2> and *The Queen v Rebecca Katherine Krutsky* [1998] ACTSC 188 (9 April 1998) per Gallop J., para. 1 <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/1998/188.html?stem=0&synonyms=0&query=act%20consol_act%20sca1933183%20s13#disp2>, *Hadba v R* [2004] ACTSC 62 (27 July 2004) per Higgins CJ and Crispin J, para. 2 <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/act/ACTSC/2004/62.html?stem=0&synonyms=0&query=act%20consol_act%20sca1933183%20s13#disp2>, all accessed 10 August 2015.

4.62 These provisions counter a person being given treatment that is contrary to their wishes, except in narrow circumstances expressly permitted by the Bill. In so doing, they foster observance of Human Rights Act:

a. section 19 (humane treatment when deprived of liberty); and

b. section 10 (freedom from torture and cruel, inhuman and degrading treatment).

4.63 The right to health is also directly protected by the Bill's information and consultation requirements. As discussed in segment 2, international case law indicates that the right to health is incorporated in the right to life and the freedom from inhuman and degrading treatment, respectively supplied by Human Rights Act sections 9 and 10.

4.64 Further, in its General Comment No. 14 on the right to health, the UN Committee on Economic, Social and Cultural Rights states that there is a tight nexus between it and the 'right to seek, receive and impart information and ideas concerning health issues'.[121] The Committee describes this latter right as foundational to what it characterises as the essential 'accessibility' element of the right to health, as well as to the freedom of expression, declared by CCPR Article 19(2).[122]

4.65 Article 19(2) is the source of Human Rights Act section 16(2). Section 16(2) declares:

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.

ACT Civil and Administrative Tribunal and fair trial

4.66 International law makes clear that the right to fair trial, supplied by section 21 of the Human Rights Act, applies not only to criminal, but also civil, proceedings.[123] The Bill, like the current Act, contains many clauses that:

a. empower ACAT to conduct civil proceedings to make or review orders;[124] and

b. impose duties on ACAT that are ancillary to its order making and reviewing[125].

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[121] 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.

[122] ibid.

[123] For instance, in its latest General Comment on Article 14, the United Nations Human Rights Committee states in its third paragraph under 'I. General comments' that: 'The first sentence of paragraph 1 [of Article 14] sets out a general guarantee of equality before courts and tribunals that applies regardless of the nature of proceedings before such bodies' (United Nations Human Rights Committee, *General comment no. 32, Article 14, Right to equality before courts and tribunals and to fair trial*, 23 August 2007, CCPR/C/GC/32 <http://www1.umn.edu/humanrts/gencomm/hrcom32.html>, accessed 19 March 2015).

[124] These clauses include, but are not limited to: 46 (Order for release); 55G (Making of electroconvulsive therapy order); 55G (Making of electroconvulsive therapy order); 55H (Content of electroconvulsive therapy order); 55JA (What ACAT must take into account - emergency electroconvulsive therapy order); 55K (Making of emergency electroconvulsive therapy order); 55L (Content of emergency electroconvulsive therapy order); new section 72 (6) (Review of detention under court order) that would be provided by Amendment 2.25 in Bill Schedule 2 (Legislation amended) Part 2.1 (Mental Health (Treatment and Care) Act 1994); 139CH (Interstate transfer – person under psychiatric treatment order or community care order); and 139CI (Interstate transfer – person under forensic psychiatric treatment order or forensic community care order).

[125] These clauses include, but are not limited to: clause 55D (Consultation by ACAT - electroconvulsive therapy order); clause 55E (ACAT must hold hearing - electroconvulsive therapy order); clause 55F (What ACAT must take into account - electroconvulsive therapy order); and those clauses in Chapter 11 (ACAT procedural matters).

4.67 ACAT is not a court and its members have no tenure. Rather, it is a tribunal comprised of members whose respective terms vary in length, depending on what kind of member they were appointed as, under the *ACT Civil and Administrative Tribunal Act 2008* (ACAT Act).[126] Further, as section 8 of the ACAT Act states, ACAT is not bound by the rules of evidence.

4.68 Nonetheless, those above cited Bill provisions that enable or require ACAT proceedings, and impose ancillary duties on ACAT, are compatible with the right to a fair trial.[127] Further, the same Bill provisions are also compatible with the right to recognition and equality before the law, provided by section 8 of the Human Rights Act. The compatibility of these provisions is clearly borne out by, among other things, a part of international law and a case of the United Kingdom High Court.[128]

4.69 In the case, *H v MHRT, North and East London Region* (2000), the Court held that 'there was nothing unlawful [under the United Kingdom *Human Rights Act 1998*] about a tribunal system that was of an inquisitorial nature…'[129] The tribunal which the case challenged was the United Kingdom's Mental Health Review Tribunal. There has been no overruling of this case, or of any analogous case, by a superior appellate court of any common law country.

4.70 The part of international law relevant here is Principle 17 of the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care ('the UN Principles'). While these Principles do not form a treaty, they were agreed with Australia's full support.[130] Further, they do give valuable guidance on how the CCPR and CESCR apply, in respect of people with mental illness/es and/or disorder/s, regardless of whether they are adult, juvenile, or imprisoned people.[131]

4.71 UN Principle 17 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.[132]

4.72 The Definitions in the UN Principles include a definition of 'review body'. It is: 'the body established in accordance with Principle 17 to review the involuntary admission or retention of a patient in a mental health facility'.[133]

[126] Section 98 of the *ACT Civil and Administrative Tribunal Act 2008* (ACAT Act), ACT Legislation Register <http://www.legislation.act.gov.au/a/2008-35/default.asp>, accessed 19 March 2015.

[127] Full citation for Human Rights Act, at footnote 1.

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

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

[130] 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 Jan. 2014.

[131] Full citation of treaties, at footnote 6.

[132] UN General Assembly Resolution 46/119, 17 December 1991.

[133] ibid.

4.73 In this way, the UN Principles expressly approve of administrative bodies being the makers of orders for the treatment, care and support of persons who have, or appear to have, mental illness/es, on three conditions: one, so the administrative bodies are constituted under law; two, they are independent of the Executive; and, three, they conform with due process rights.

4.74 Certain provisions of the ACAT Act mandate that ACAT conforms with due process rights. Section 21(1) of the Human Rights Act explicitly declares that such rights are part of the Human Rights Act section 21 right to a fair trial.[134] They are also a part of the right to recognition and equality before the law, which is supplied by section 8 of the Human Rights Act.

4.75 Certain Bill clauses are also express responses to the due process protections required by Human Rights Act sections 21 and 8 and UN Principle 17. These include, but are not limited to:

a. clause 55E, which would compel ACAT to hold a hearing into an electroconvulsive therapy (ECT) order matter; and

b. clause 139CH(3), which would dictate that ACAT will hold a hearing into an interstate transfer order matter.[135]

Powers to inspect private psychiatric facilities

4.76 Bill clause 135B(1) (Powers of inspection) would supply inspectors, who were appointed under clause 135, with powers to inspect private psychiatric facilities for compliance with patient safety and other relevant standards. More specifically, clause 135B(1) enables such an inspector to, at any reasonable time, enter premises licensed as a private psychiatric facility, and:

a. inspect them, and any equipment used there, in connection with treatment, care or support of the kind provided for by the Bill; and

[134] These ACAT Act provisions include, but are not limited to, sections 7, which requires 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'; 30, which allows a person appearing before ACAT to be represented by a lawyer or another appropriate advocate; 41A, which gives a witness before ACAT the same protection as a witness in an ACT Supreme Court proceeding, and gives a lawyer or anyone else representing a party before ACAT, the same protection and immunity as a party, or a party's barrister, appearing before the Supreme Court; 22B and 60, which dictate that the reasons for an ACAT decision must be given to the parties to that decision, if they so request; 90, which states that before allocating an ACAT member to an application, the general president must consider its nature and complexity, whether to allocate a member with special qualifications or experience, and any other consideration stated in a law that authorises ACAT proceedings; 86(1), which enables a party to an application to appeal to the Supreme Court on a question of fact or law; and 83, which holds that if the parties to an application or an appeal jointly apply to have the matter removed to the Supreme Court, ACAT must order that, and if one party applies to have a matter so removed, ACAT may so order, if it considers that appropriate.

[135] These provisions also include sections:

a. 36S, which would compel ACAT to hold a hearing before making anyone subject to a mental health order. As stated in the Bill's Dictionary provided by Bill clause 3, '***mental health order*** *means a psychiatric treatment order, a community care order, or a restriction order*'. Section 36S would be relocated into Chapter 6 (Emergency detention) of the *Mental Health Act 2015*, by the commencement of the *Mental Health Act 2015*, Schedule 2, Amendment 2.37.

b. 48X, which would dictate that ACAT will hold a hearing before making anyone subject to a forensic mental health order. As stated in the Bill Dictionary provided by clause 3, '***forensic mental health order*** *means a forensic psychiatric treatment order or a forensic community care order*'. Section 48X would be relocated into Chapter 7 (Forensic mental health) of the *Mental Health Act 2015*, by the commencement of the *Mental Health Act 2015*, Schedule 2, Amendment 2.39.

c. 78, which would reinforce section 90 of the ACAT Act by providing that for several kinds of proceedings authorised by the Mental Health Act, such as those on mental health and forensic mental health orders, ACAT must be constituted by 'a presidential member and a non-presidential member with a relevant interest, experience or qualification'. Section 78 would be relocated into Chapter 11 (ACAT procedural matters) of the *Mental Health Act 2015* by commencement of *Mental Health Act 2015*, Schedule 2, Amendment 2.42.

d. 141, which would provide that an appeal to the 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 section 80(1) of the current Act, the discrimination commissioner, or anyone else with the Court's leave. Section 141 would be relocated into Chapter 17 (Miscellaneous) of the *Mental Health Act 2015*, by the commencement of *Mental Health Act 2015*, Schedule 2, Amendment 2.46.

b. inspect books, documents or other records that relate to the conduct of the private psychiatric facility at the premises; and

c. require the premises' occupier to give the inspector copies of information, books, documents or other records relating to the conduct of the facility at the premises.

4.77 These powers would pass the section 28 test set by the Human Rights Act, for at least five main reasons.

4.78 First, the UN Human Rights Committee has emphasised that it is unacceptable for States to fail to meet CCPR Article 10 (1),[136] which reads: '1. All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person'. Further, that Committee states in its latest General Comment on Article 10 that 'Article 10, paragraph 1…applies to any one deprived of liberty under the laws and authority of the State who is held in prisons, hospitals - particularly psychiatric hospitals - detention camps or correctional institutions or elsewhere'.[137]

4.79 Second, Article 10 is much reflected in:

a. section 19 (Humane treatment when deprived of liberty) of the Human Rights Act;

b. the section 5(d) Object of the Bill, which is to 'facilitate access by people with a mental disorder or mental illness to services provided in a way that recognises and respects their rights, inherent dignity and needs'; and

c. the section 6(e) Principle of the Bill, which is that 'a person with a mental disorder or mental illness has the right to access the best available treatment, care or support relating to the person's individual needs'.

4.80 Third, people reasonably expect facilities that deliver health and/or community care services to be safe,[138] because they exist to provide a *therapeutic* environment, not a potentially injurious or fatal one.

4.81 Fourth, there are many international human rights law cases that declare people should have a low expectation of privacy in spaces outside of regular, private residences.[139] These include cases which found no violations of the right to privacy where transport inspectors, authorised to do so by law, have entered the sleeping spaces of boats[140] and trucks[141].

[136] UN Human Rights Committee, *International Covenant on Civil and Political Rights General Comment No. 21: Article 10 (Humane Treatment of Persons Deprived of Their Liberty)*, UN Doc HRI\GEN\1\Rev.1, 10 April 1992, para. 4.

[137] ibid, para.2.

[138] In *R (Wilkinson) v. Responsible Medical Officer Broadmoor Hospital* [2002] WLR 419, the United Kingdom Court of Appeal suggests that an express power of detention includes, where necessary, a power to search, because it is 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 the United Kingdom High Court case *R. v Home Secretary, ex parte Leech* [1994] QB 198. *Osman v. United Kingdom* (2000) 29 EHRR 245 also states that, under the right to life, there is an obligation on authorities to take preventative measures to protect those at risk from the criminal acts of another person.

[139] 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.

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

[141] *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 it '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).

4.82 Fifth, there is also a large body of international case law that states it is permissible to conduct entries, searches, and seizures, without warrants, if these two conditions obtain:

a. a statute expressly enables those warrantless entries, searches, and seizures, in *exigent* situations that *cannot be anticipated with any certainty and do not allow a warrant to be obtained in the time in which the entries, searches and seizures need to occur for urgent safety reasons*; and

b. each entry, search, and seizure, must be performed only to the extent necessary, and in accordance with, the statutory requirements that allow them.[142]

5. What are the Bill clauses about?

Chapter 1 Preliminary

1 Name of Act simply provides that, if enacted, the Bill will be entitled *Mental Health Act 2015*.

2 Commencement provides that if the Bill is enacted, it will commence immediately after the commencement of the *Mental Health (Treatment and Care) Amendment Act 2014*. The commencement of the *Mental Health (Treatment and Care) Amendment Act 2014* is scheduled to be 12 November 2014.

3 Dictionary states that the Dictionary at the end of the Bill is part of the Bill.

4 Notes states that all of the Bill's Notes are explanatory only, and not a part of the Bill.

4A Offences against Act—application of Criminal Code etc states that there is legislation that will apply to the proposed *Mental Health Act 2015*, including:

- section 133 of the *Legislation Act 2001* (ACT) ('Legislation Act'), which defines the worth of a penalty point; and
- Chapter 2 of the *Criminal Code 2002* (ACT) ('Criminal Code'), which lays down general principles of criminal responsibility, such as burdens of proof and general defences, and defines terms used for offences to which the Criminal Code applies.

Chapter 2 Objects and important concepts is the Chapter into which sections 5 to 13 would be relocated from the *Mental Health (Treatment and Care) Act 1994* ('the Act'), as amended by the *Mental Health (Treatment and Care) Amendment Act 2014* ('the Amendment Act'). That relocation would be effected by the commencement of *Mental Health Act 2015*, Amendment 2.33 Schedule 2

The Bill provides for no amendments to sections 5 to 13. As the title of Chapter 2 indicates, sections 5 to 13 regard Objects of the Bill or concepts that respectively underpin much of the Bill.

[142] In *R. v. M. (M.R.)*, the Supreme Court of Canada held, in a majority decision, that the seizure of marijuana from a student searched during a school dance did not infringe his rights under section 8 of the Charter of Human Rights and Freedom, which provides that 'Everyone has the right to be secure against unreasonable search or seizure', a right that broadly correlates with section 12(a) of the *Human Rights Act 2004* (ACT). The majority of the Court stated that a student's reasonable expectation of privacy in the school environment is 'significantly diminished', as school authorities are responsible for 'providing a safe environment and maintaining order and discipline in the school' and they need no warrant, so long as they are not an agent of the state, and the standard required is reasonable belief ([1998] 3 S.C.R. 393). Also, see justification of warrantless searches statutorily provided for in exigent circumstances, in *R. v. Grant* (1993) 84 C.C.C. (3d) 173 (S.C.C.) at p.188.

Chapter 3 Rights of people with mental disorder or mental illness is where Parts 3.1 to 3.3 of the Act, will be relocated into the *Mental Heath Act 2015*, upon commencement of *Mental Heath Act 2015*, Schedule 2, Amendment 2.34. As the title of Chapter 3 indicates, all these provisions regard the rights of people with mental disorder/s and/or illness/es.

Note that Schedule 2 provides for amendments in respect of the following within the Act's Parts 3.1 and 3.3:

- sections 15(1)(b)(vi) and 15(4)(g), which are in Part 3.1, and regard the information people are to be provided by the person responsible for a mental health facility or community care facility, as soon as practicable after it is decided to give those people treatment, care or support at the facility; and
- section 27(4), and its Note, which are in Part 3.3, and regard an advance consent direction that gives consent to electroconvulsive therapy (ECT).

For more details on these three amendments, see **Schedule 2 Legislation amended, Part 2.1 Mental Health (Treatment and Care) Act 1994, Division 2.1.1 Amendments**, provided by Bill clause 149.

Chapter 4 Assessments will contain Parts 4.1 and 4.2 relocated from the Act, by Amendment 2.35 in Schedule 2 of the Bill. Note that Schedule 2 of the Bill provides for amendments to the two following provisions that fall within Part 4.2:

- section 36H (Executing removal order); and
- section 36M(2) (Notice of outcome of assessment).

For more details on these two amendments, see **Schedule 2 Legislation amended, Part 2.1 Mental Health (Treatment and Care) Act 1994, Division 2.1.1 Amendments**, provided by Bill clause 149.

Chapter 5 Mental health orders will contain Parts 5.1 to 5.7 relocated from the Act, by *Mental Health Act 2015* Schedule 2, Amendment 2.36. Note that Schedule 2 provides for amendments to the following sections within Parts 5.1 to 5.7:

- sections 36R(1)(g), 36R(1)(h), and 36R(2) (Consultation by ACAT —mental health order);
- section 36Z(5)(a)(viii) (Role of chief psychiatrist—psychiatric treatment order);
- section 36ZC(5) (Powers in relation to psychiatric treatment order);
- section 36ZH(3)(a)(viii) (Role of care coordinator—community care order); and
- section 36ZK(5) (Powers in relation to community care order).

For details on these seven amendments, see **Schedule 2 Legislation amended, Part 2.1 Mental Health (Treatment and Care) Act 1994, Division 2.1.1 Amendments**, provided by Bill clause 149.

Chapter 6 Emergency detention will contain the following sections relocated from the amended Act to this Chapter, by Mental Health Act 2015, Schedule 2, Amendment 2.37:

- section **37 (Apprehension)**;
- section **38 (Detention at approved mental health facility)**; and
- section **38A (Copy of court order)**.

Bill Schedule 2 provides for no amendments to these sections.

39 Statement of action taken differs from the current Act's section 39 Statement of action requirements, by adding:

- 'authorised ambulance paramedic' to subsection (1), because authorised ambulance paramedics - not only police officers, mental health officers, and doctors - can be undertaking the section 37 apprehensions and removals of people to an approved mental health facility, about which the section 39 statements need to be made.
- paragraph (1)(d) which adds 'nature and' before the word 'extent' in that paragraph's requirement that there be recording in the section 39 statement of 'the nature and extent of the force or assistance used to enter any premises, or to apprehend the person and take the person to the facility;'.
- paragraph (1)(e), which requires the exerciser of the section 37 power to write into the statement the nature and extent of any restraint, involuntary seclusion, or forcible giving of medication, that was used when apprehending the person or taking them to the facility.
- paragraph (1)(f), which requires that the exerciser of the section 37 power to write into the statement anything else that happened when the person was being apprehended and taken to the facility that may affect the person's physical or mental health.
- paragraph (2)(b), which requires the person in charge of the facility who receives the statement to keep a register of any restraint, involuntary seclusion or forcible giving of medication included in statements.

These additions to section 39 would serve four main purposes.

First, they would ensure that the mental health professionals to whom the person is delivered, under section 37, are informed of any event the person experienced during their section 37 apprehension and removal that the professionals need to know to provide appropriate care to the person. Such events might include, for instance, that while the person was being apprehended and removed:

- they dropped a package of white powder and so may be under the influence of a drug;
- they could or would not cease assaulting their apprehenders, so the person was involuntarily secluded in the back of a paddy wagon for all of their transport to the facility; and
- the person was noisy during their apprehension, and for most of the journey, but since they hit their head against the paddy wagon, they have been conscious, but silent.

The mental health professionals are likely to need such information about the person's condition, if they are to:

- calm and reassure the person;
- maintain the safety of the person and those around them; and
- arrange timely, and otherwise appropriate, assessment and treatment of the person, including of any mental or physical deterioration, intoxication, injury, or illness, that became apparent to the people who apprehended and removed them.

Secondly, these changes to section 39 mean that, if a person is injured, during a section 37 apprehension and removal of them, the associated section 39 statement is more likely to be informative to those individuals and authorities, who lawfully can or must be told of the events leading up to the person's injury. The said individuals would include the person injured and might include, say, the person's carer or guardian. The said authorities might be ones to whom the person or their representative has complained about their injury, such as the ACT Ombudsman.

Thirdly, the new section 39 means that, if a person dies, during, or shortly after, their section 37 apprehension and removal, the associated section 39 statement is more likely to be useful to any close friends and relatives of the deceased person and to authorities who investigate the person's death.

Fourthly, section 39's newly required register of all incidences of restraint, involuntary seclusion, or forcible giving of medication that are reported in section 39 statements will enable:

- identification of any apparently anomalous occurrences of restraint, involuntary seclusion, or forcible giving of medication during section 37 apprehensions and removals, so that, if warranted, there can be inquiries into whether those occurrences involved any unlawful, or lawful, but unsafe, conduct; and
- identification and monitoring of any trends in the frequency, duration, and other characteristics of section 37 incidences of restraint, involuntary seclusion, or forcible giving of medication, including the extent to which these restrictions are:

  1) only used to the degree necessary to conduct an apprehension and removal that is safe for the apprehended and removed person, and for the person or people apprehending and removing them, and for anyone else within the vicinity of the apprehension and removal; and

  2) only when there is no less restrictive, reasonable way of apprehending and removing the person that is commensurate with maintaining the safety of all those people mentioned in 1).

Such trends identification and monitoring will be instructive of:

- root cause analysis of any trends in unlawful or unsafe uses of restraint, involuntary seclusion, and forcible giving of medication, during section 37 apprehensions and removals;
- design and implementation of any training and procedures that bear on section 37 apprehensions and removals; and
- evaluation of that training and of those procedures, and of any changes made to them, in terms of impacts on the frequency, duration, safety levels, and other characteristics of section 37 uses of restraint, involuntary seclusion, and forcible giving of medication.

Chapter 6 will also contain the following sections relocated into it from the amended Act, by *Mental Health Act 2015*, Schedule 2, Amendment 2.38:

- section **40 (Initial examination at approved mental health facility)**;
- section **41 (Authorisation of involuntary detention)**; and
- section **41AA (Medical examination of detained person)**.

The Bill provides for no amendments to these three provisions. For explanation of any of them, see the Explanatory Statement on the Amendment Act.

41A Notification of Magistrates Court about emergency detention or release from emergency detention would add a subsection (2) to the current Act's section 41A. (The Amendment Act, upon its commencement, will not amend section 41A.)

The added subsection (2) would mandate that the person in charge of the mental health facility notify the Court of the reasons for detention of the Court referred person, if that person is detained at the facility under section 38 (Detention at approved mental health facility) or section 41 (Authorisation of involuntary detention).

The current section 41 only requires that the Court is notified of the results of an examination conducted by a doctor under an order enabled by section 309(1) of the Crimes Act. This requirement, in subsection (1) of the current section 41A would still be provided by subsection (1) of clause 41A of the *Mental Health Act 2015*.

41AB Treatment during detention would remake section 44 (Treatment during detention) of the Amendment Act, without changing its meaning.

Section **42 (Notification of certain people about detention)** is relocated to this chapter from the amended Act, by Amendment 2.39 in Schedule 2 of the Bill.

There are also some amendments of sections 42(3) and (4) by Bill Schedule 2, Amendment 2.14.

Section 17 of the Amendment Act 2014 omits section 43.

Section **45 (Offence—communication during detention)** would be relocated to this Chapter from the amended Act, by *Mental Health Act 2015*, Schedule 2, Amendment 2.40. For an explanation of section 45, see the Explanatory Statement on the Amendment Act and the Explanatory Statement on the current Act.

46 Order for release differs from section 46 of the current Act as amended by the Amendment Act, in two main ways.

First, it is differently worded to make it easier to read and comprehend.

Second, it provides that the doctor's examination of the detained person occurs under section 41AA (Medical examination of detained person). Section 41AA is a new provision that would be supplied by the commencement of the Amendment Act. The current Act's section 46 states that this examination occurs under the current Act's section 43 (Medical examination).

Third, new clause 46 provides that the doctor who examined the person under section 41AA, or the chief psychiatrist, or ACAT, must, as soon as practicable, order the release of the person, if their detention is no longer justified under *any* provision of section 41. The current section 46 only provides that the doctor who examined the person, or the chief psychiatrist, or ACAT, must make that order, if the person's detention is no longer justified under sections 41(1) or (2).

47 Duty to release would impose on the person in charge of an approved mental health facility the duty of releasing a person detained under section 41, in accordance with an order under clause 46.

Clause 47(1)(b) would mandate that if no order for release is made under clause 46, then, subject to any other ACAT order, the person is to be released at the end of the period of detention authorised under section 41 (Authorisation of involuntary detention). Section 41 would be relocated into the *Mental Health Act 2015* from the amended Act, by the commencement of *Mental Health Act 2015*, Amendment 2.38 in Schedule 2.

See the account of section 41 in the Amendment Act's Explanatory Statement for explanation of the terms of detention that section 41 permits and in what circumstances and on whose authority.

Chapter 7 Forensic mental health would contain Part 7.1 (Forensic mental health orders) and Part 7.2 (Affected people) relocated from the Act, by the commencement of *Mental Health Act 2015*, Schedule 2, Amendment 2.41.

Note that Schedule 2 would amend these provisions of Parts 7.1 and 7.2:

- section 48S (Definitions—pt 7.1);
- the heading of section 48T to change it to 'Applications for forensic mental health orders—detainees etc';
- sections 48T(1) and (2) (Applications for forensic mental health orders—detainees etc);
- section 48Y(1)(b) (What ACAT must take into account—forensic mental health order);
- section 48ZA(1)(b) (Forensic psychiatric treatment order);
- section 48ZC(6)(a)(vii) (Role of chief psychiatrist—forensic psychiatric treatment order);
- section 48ZG(5) (Powers in relation to forensic psychiatric treatment order);
- section 48ZH(1)(b) (Forensic community care order);
- section 48ZJ(4)(a)(vii) (Role of community care coordinator—forensic community care order); and
- section 48ZN(5) (Powers in relation to forensic community care order).

Chapter 8 Correctional patients would contain Parts 8.1 (Preliminary) to 8.4 (Leave for correctional patients) relocated from the Act, by *Mental Health Act 2015*, Schedule 2, Amendment 2.42.

The Bill provides for no amendments to any of the provisions in Parts 8.1 to 8.4.

Chapter 9 Electroconvulsive therapy and psychiatric surgery

Part 9.1 Preliminary—ch 9

49 Definitions would bring certain definitions to the beginning of this Part, from within several provisions of this Chapter, from the beginning of several of this Chapter's Divisions, or the Dictionary at the end of the Chapter.

These definitions are for the terms:

- ***electroconvulsive therapy***;
- ***electroconvulsive therapy order***;
- ***emergency electroconvulsive therapy order***;
- ***neurosurgery***; and
- ***psychiatric surgery***.

These definitions would give these terms the same content as the same definitions within the current Act, except in respect of ***psychiatric surgery***, which is redefined as 'specialised neurosurgery for psychiatric conditions'.

50 Form of consent is a far more concise provision than the equivalent one in the current Act. This concision is permitted by the new section 8 decision-making capacity principles supplied by the Amendment Act.

However, clause 50 would preserve the safeguard in the current equivalent provision that the consent must be indicated in writing, and with a signature, provided by the person giving consent, in the presence of a witness apart from:

- the doctor proposing to perform the ECT or psychiatric surgery; and
- the person seeking the consent, should they be a different person to the doctor.

Part 9.2 Electroconvulsive therapy

Division 9.2.1 Administration of electroconvulsive therapy

The Amendment Act does not address the provisions regarding ECT administration, which is why all references, below, are to provisions of the current Act.

51 When electroconvulsive therapy may be administered provides that ECT may be administered to an adult only:

- via the procedures dictated by clauses 52 (Adult with decision-making capacity) and 53 (Adult without decision-making capacity); and
- to a person who is at least 12 years of age, but under 18 years of age, as provided by clauses 54 (Young person with decision-making capacity) and 55 (Young person without decision-making capacity).

Clause 51 would also expressly prohibit the administration of ECT to a person under 12 years old.

The current Act provides for no limits on the age of a person to whom ECT may be administered, except in so far as it allows an emergency ECT order to be made only for a person who is at least 16 years old.

52 Adult with decision-making capacity would permit ECT to be administered to a person 18 years or over, if they have:

- consented to that;
- not withdrawn that consent, orally or in writing; and
- not had ECT administered nine or more times since giving the consent, or, if the consent was for less than nine times, not had ECT administered for that number of times or more.

The decision-making capacity principles at section 8 of the Act as amended by the Amendment Act ('the amended Act') are critical to the interpretation of this provision.

The current Act only refers to a person's decision-making capacity in relation to ECT when it comes to ACAT making an emergency ECT order for a person over 16 years of age, who lacks the capacity to make decisions about ECT.

53 Adult without decision-making capacity would allow ECT administration to a person who is 18 years of age or more who:

- lacks decision-making capacity to consent to ECT; but
- has an advance consent direction consenting to it;
- does not refuse or resist ECT administered in accordance with the direction; and
- is administered the ECT in accordance with the direction.

It would also permit ECT to be administered to adults lacking the capacity to make decisions about ECT, if:

- the ECT is administered in accordance with an ECT order or an emergency ECT order in force in relation to the person and the person either does not refuse or resist that administration; or
- the person is subject to a psychiatric treatment order or forensic psychiatric treatment order.

The decision-making capacity principles at section 8 of the amended Act are critical to the interpretation of this provision.

54 Young person with decision-making capacity would permit the administration of ECT to a person who has consented to that and not withdrawn that consent, orally or in writing, and is:

- 12 to 15 years old, if the ECT is administered in accordance with an ECT order in force in relation to that person; and
- 16 or 17 years old, if the ECT is administered in accordance with an ECT order or emergency ECT order in force in relation to that person.

The decision-making capacity principles at section 8 of the amended Act are critical to the interpretation of this provision.

55 Young person without decision-making capacity would permit the administration of ECT to a person who lacks decision-making capacity to consent to that, so long as:

- for a 12 to 15 year old, the ECT is administered in accordance with an ECT order; or
- for a 16 or 17 year old, the ECT is administered in accordance with an ECT order or emergency ECT order; and
- either the person does not refuse or resist, or the person is subject to a psychiatric treatment order or a forensic psychiatric treatment order.

The decision-making capacity principles at section 8 of the amended Act are critical to the interpretation of this provision.

55B Offence—unauthorised administration of electroconvulsive therapy provides in its:

- subclause (1) that it is an offence for anyone other than a doctor to administer ECT to a person and that the maximum penalty for that offence is 100 penalty units, imprisonment for 1 year, or both; and
- subclause (2), that it an offence for the doctor to administer ECT contrary to the requirements of Division 9.2.1 (Administration of ECT) and that the maximum penalty for that offence is 50 penalty units, imprisonment for 6 months, or both.

Division 9.2.2 Electroconvulsive therapy orders

55C Application for electroconvulsive therapy order would permit the chief psychiatrist or doctor to apply to ACAT for an ECT order in relation to a person, if the chief psychiatrist or doctor believes, on reasonable grounds, that ACAT could make such an order for that person.

If the person is under 18 years of age, clause 55C also requires that:

- the application is supported by the evidence of another doctor; and
- at least one of the applicants is a child and adolescent psychiatrist.

Clause 55C(4) defines ***child and adolescent psychiatrist***.

55D Consultation by ACAT—electroconvulsive therapy order would specify a list of people who ACAT 'must, as far as practicable' consult, before making an ECT order in relation to a person who is not subject to a mental health order.

55E ACAT must hold hearing—electroconvulsive therapy order would dictate that ACAT cannot make an ECT order, without holding a hearing into the matter.

55F What ACAT must take into account—electroconvulsive therapy order would dictate that ACAT will, before making an ECT order, take into account all of a number of considerations that clause 55F would specify. These considerations include, among many others, whether the person:

- consents to ECT;
- refuses to consent to ECT; or
- has the decision-making capacity to consent to ECT.

Accordingly, the section 8 decision-making principles are critical to the interpretation of this clause.

55G Making of electroconvulsive therapy order would specify a number of matters of which ACAT must be satisfied, before making an ECT order for a person, on an application under section 55C, when the person is of at least:

- 12 years old; or
- 12 years old, but under 18 years old.

The matters clause 55G would specify for a person who is at least 12 years old are different to those it would specify for a person who is of at least 12 years old, but under 18 years old.

One of the specified matters for *both* age cohorts would turn on the person's decision-making capacity to consent to ECT. Accordingly, the section 8 decision-making principles are critical to the interpretation of this clause.

Paragraph (3) of this clause would compel ACAT to, as soon as practicable after it has made an ECT order under clause 55G, give a copy of the order to the:

- person in relation to whom the order is made;
- person who applied for the order;
- people consulted under section 55D (Consultation by ACAT—electroconvulsive therapy order).

55H Content of electroconvulsive therapy order provides that the ECT order must specify:

- the matters, under sections 55G(1) or (2) (Making of electroconvulsive therapy order), of which ACAT is satisfied; and
- the maximum number of times ECT may be administered to the person under the order.

Clause 55H would also place certain conditions on the number of times the order may authorise ECT administration.

55I Person to be told about electroconvulsive therapy order would compel the person in charge of the facility to ensure a person is:

- told about their ECT order, and the procedures authorised under it, before the person receives ECT, under the order, in that facility; and
- told in a 'language and way of communicating that the person is most likely to understand'.

Clause 55I would also stipulate that both of these requirements are to be fulfilled, irrespective of whether the person was present when the ECT order was made.

Division 9.2.3 Emergency electroconvulsive therapy orders

55J Application for emergency electroconvulsive therapy order would permit the chief psychiatrist and doctor to jointly apply to ACAT for an emergency ECT order in relation to a person, if a certain condition obtains. That condition is that the chief psychiatrist and doctor believe on reasonable grounds that ACAT could reasonably make an ECT order for the person.

Clause 55J also requires that an application for an ECT order for the person accompany the application for an emergency ECT order.

Note this clause importantly interrelates with sections:

- 79 (Applications);
- 80 (Appearance);
- 53(3)(b) (Adult without decision making capacity); and
- 55(2)(b) (Young person without decision-making capacity).

55JA What ACAT must take into account—emergency electroconvulsive therapy order would dictate that before making an ECT order, ACAT will take into account all of a number of considerations that specified by clause 55F.

Note that section 79A(3) (Notice of hearing) does not apply in relation to the making of an emergency ECT order.

55K Making of emergency electroconvulsive therapy order would specify a number of matters of which ACAT must be satisfied, before making an emergency ECT order for a person, on an application under section 55J, when the person is of at least 16 years old.

Some of these matters would turn on the person's decision-making capacity to consent to ECT. Accordingly, the section 8 decision-making principles are critical to the interpretation of this clause.

55L Content of an emergency electroconvulsive therapy order would provide that the emergency ECT order must state the number of times ECT may be administered to a person, being not more than three times and the number of days in which the order expires, being not more than seven days, after the order is made.

Note that under section 87, ACAT will be required to give a copy of the order, within 24 hours, to certain people it specifies.

56 Effect of later order would terminate an emergency ECT order in relation to a person, if ACAT makes an ECT order in relation to the same person.

Division 9.2.4 Records of electroconvulsive therapy

57 Doctor must record electroconvulsive therapy would require, via its subsection (1), that a doctor who administers ECT makes a record of that administration, including whether it was:

- in accordance with an ACAT order; and
- with the person's consent.

It would also dictate in its subsection (2) that the doctor must give the record to the person in charge of the facility where the ECT was administered.

Under this section, a doctor's failure to comply with either requirement would be an offence, with a maximum penalty of 20 penalty units.

58 Electroconvulsive therapy records to be kept for 5 years would provide that a maximum penalty of 20 penalty units applies, if the person in charge of a psychiatric facility fails to keep the record of ECT required by section 57(2) for at least 5 years after the day the record is given.

Part 9.3 Psychiatric surgery

59 Performance on people subject to orders of ACAT would permit the performance of psychiatric surgery on a person, irrespective of any order that ACAT may have made in relation to that person.

60 Psychiatric surgery not to be performed without approval or if person refuses would make it an offence for a doctor to perform psychiatric surgery on a person, if the doctor has no approval from the chief psychiatrist to do so, or if the doctor has been told, under section 66, that the person refuses to have the surgery.

This clause would also make the maximum penalty for this offence 100 penalty units, imprisonment for 1 year, or both.

61 Application for approval would permit a doctor who proposes to perform psychiatric surgery on a person to apply to the chief psychiatrist for their approval to do so. It would also require this application to be in writing and accompanied by either:

- a copy of the person's consent; or
- a copy of an order of the Supreme Court's consent under section 65.

It would further compel the doctor give a copy of that application to the person, as soon as practicable after giving the application to the chief psychiatrist.

62 Application to be considered by committee would mandate that the chief psychiatrist, as soon as practicable after receiving a section 61 application, give a copy of it to the chairperson of the committee appointed under section 67. Clause 62 would also compel that chairperson to:

- give written notification of the application to a number of specified people, as soon as practicable after receiving it;
- convene a meeting of the committee to consider the application; and
- give a written report to the chief psychiatrist that includes a number of items specified in clause 62.

Clause 62 would prohibit the committee recommending that the chief psychiatrist approve the performance of psychiatric surgery, unless certain conditions that would be specified by clause 62 obtain. Finally, clause 62 would dictate that the chief psychiatrist must ensure a copy of the committee's report is placed on the subject person's record.

63 Requirement for further information would mandate that if the committee that is considering an application to perform psychiatric surgery requests further information or documents relevant to the application, the chief psychiatrist will require, by written notice, that the applicant doctor give that information or documents to the chief psychiatrist.

Clause 63 would also relieve the committee of having to consider the application, until the required information or documents were given to the chief psychiatrist.

Finally, clause 63 would compel the chief psychiatrist to give the committee chairperson any information or documents given to the chief psychiatrist pursuant to the committee's request for them.

64 Application to be decided in accordance with committee's recommendation would compel the chief psychiatrist to decide an application, under section 61 (Application for approval), in accordance with the committee's recommendation on it.

65 Consent of Supreme Court would allow the Supreme Court to consent to the performance of psychiatric surgery on a person, on a doctor's application to the Court for that consent, but only if the Court is satisfied of all the matters clause 65 would specify. One of those matters turns on the person's decision-making capacity to consent to psychiatric surgery. Accordingly, the section 8 decision-making principles are critical to the interpretation of this clause.

66 Refusal of psychiatric surgery would pertain to a person who has consented to psychiatric surgery, or for whom the Supreme Court has made an order consenting to the psychiatric surgery under clause 65.

Clause 66 would make clear that the person may, before the surgery is performed, tell the chief psychiatrist or anyone else, that the person refuses to have psychiatric surgery. It would also expressly permit the person to tell their refusal, orally or in writing.

If the person told is not the chief psychiatrist, clause 66 would compel whoever is told to inform the chief psychiatrist of the refusal. It would also makes failing to do so on pain of a maximum penalty of 50 penalty units, imprisonment for 6 months, or both.

Clause 66 would also dictate that if the chief psychiatrist approved the psychiatric surgery, under section 64, and the chief psychiatrist is told of a person's refusal, the chief psychiatrist must immediately:

- tell the doctor who is to perform the psychiatric surgery of the refusal; and
- ensure that written documentation of the refusal is placed on the person's record.

Clause 66 would stipulate that if the chief psychiatrist is told that a person refuses to have psychiatric surgery performed, any consent to the psychiatric surgery given by the person, or any Supreme Court order under section 65, ceases to have effect.

Clause 66 would further stipulate that, if immediately before the date of the refusal, an application for the approval of the psychiatric surgery has been made, but has not been decided, the application is taken to have been withdrawn on that date, and any approval given by the chief psychiatrist for the psychiatric surgery ceases to have effect.

67 Appointment of committee would specify how the:

- committee referred to in the above clauses will be constituted;
- questions arising at the committee are to be decided; and
- committee members are to be remunerated.

Part 19.3 of the Legislation Act is relevant, here, because it contains certain requirements for the making of appointments, including acting appointments.

Chapter 10 Referrals by courts under Crimes Act and Children and Young People Act would contain the amended Act's sections 68 to 75 relocated from the amended Act, by *Mental Health Act 2015*, Schedule 2, Amendment 2.43.

Note that Schedule 2 would amend insert a new section into Chapter 10, being section 72(6). This amendment is explained, under Schedule 2, Amendment 2.43, below.

Chapter 11 ACAT procedural matters would contain the amended Act's sections 76 (Meaning of *subject person*—ch 11) to 87 (Who is given a copy of the order), relocated from the amended Act, by *Mental Health Act 2015*, Schedule 2, Amendment 2.44. Of these sections, Schedule 2 provides for amendments to:

- 78(1)(g) and (h) (When ACAT must be constituted by more members);
- 79A (3)(e) (Notice of hearing); and
- 87 (1)(ga) (Who is given a copy of the order).

Chapter 12 Administration would contain Parts 12.1 (Chief psychiatrist and mental health officers) to 12.5 (Sharing information—government agencies) of the amended Act relocated into this Bill, by *Mental Health Act 2015*, Schedule 2, Amendment 2.45. Schedule 2 contains no amendments to any provisions in Parts 12.1 to 12.5.

Chapter 13 Private psychiatric facilities

Part 13.1 Preliminary

123 Definitions—ch 13 would define, for Chapter 13, the terms:

- ***inspector***;
- ***licence***;
- ***licensed premises***;
- ***licensee***, and
- ***private psychiatric facility***.

Part 13.2 Licences

124 Meaning of *eligible person*—pt 13.2 would define the term ***eligible person*** for Part 13.2.

125 Licence—requirement to hold would provide for two offences.

One would be it is an offence for a person to operate a private psychiatric facility, while not holding a licence to do so. The maximum penalty for this offence would be 50 penalty units, imprisonment for 6 months, or both.

The second would be it is an offence for a person to be a partner in a partnership operating a private psychiatric facility, when no partner in the partnership holds a licence to operate the facility. This offence would have a maximum penalty of 50 penalty units, imprisonment for 6 months, or both.

126 Licence—application would permit a person to apply to the Minister for a licence to operate a private psychiatric facility and lay down the conditions of operating such a facility. It would allow the Minister to:

- write a request asking the applicant to give additional information or documents reasonably needed to decide the application; and
- refuse to further consider the application, if the applicant does not fulfill that request from the Minister.

127 Licence—decision on application would enable the Minister to issue a licence to operate a private psychiatric facility, on application under section 126, if the Minister were to be satisfied, on reasonable grounds, of all of a number of matters that clause 127 would specify.

Further, clause 127 would:

- stipulate that the licence must state conditions about the maximum number of people for whom treatment, care or support may be provided at the licensed premises; and
- allow the licence to include a number of particular conditions enumerated in the clause, as well as anything else that the Minister is satisfied on reasonable grounds is appropriate.

128 Licence—term and renewal of licence would require that the licence state a term for the licence and that that term be one that is up to three years. Clause 128 would also:

- allow a licensee to apply for renewal of licence, in writing, to the Minister; and
- enable the Minister to renew the licence for a up to three years, if satisfied on reasonable grounds of the matters regarding the applicant and premises that section 126(2) would mention.

129 Licence—transfer of licence would permit a licensee to apply to the Minister to transfer a licence to someone else and specify the conditions of applying. It would also empower the Minister to:

- write a request asking the proposed new licensee to give additional information or documents reasonably needed to decide the application and to refuse to consider the application further, if the proposed new licensee does not fulfill that request;
- transfer the licence to the proposed new licensee, if the Minister is satisfied on reasonable grounds of two particular matters that would be specified in clause 129; and
- amend the transferred licence's conditions, if the Minister is satisfied on reasonable grounds that the amendment is in the best interests of the people to whom treatment, care or support will be provided under the licence.

130 Licence—amendment initiated by Minister would permit the Minister to amend a licence, by written notice, on the Minister's own initiative, if satisfied on reasonable grounds that the amendment is in the best interests of people to whom treatment, care or support will be provided under the licence. Clause 130 would also:

- specify the conditions on the Minister being allowed to do so, none of which apply if the licensee agrees, in writing, to the amendment; and
- declare that the amendment takes effect, on the day the amendment notice is given to the licensee, or a later day stated in the notice.

131 Licence—amendment on application by licensee would allow the licensee to apply for an amendment to their licence. It would also:

- stipulate what the Minister must do in response to such an application;
- permit the Minister to do so, if satisfied on reasonable grounds that the amendment is in the best interests of people to whom treatment, care or support will be provided under the licence; and
- declare that the amendment takes effect on the day the amendment notice is given to the licensee or a later day stated in the notice.

132 Licence—surrender would allow a licensee to surrender their licence to the Minister, by giving the Minister the licence and written notice of its surrender. It would also state that the surrender takes effect, on the day the notice is given to the Minister, or a later day stated in the notice.

133 Licence—cancellation by notice would empower the Minister to cancel a licence, by written notice, if satisfied, on reasonable grounds, that the licensee has failed to comply with a condition of the licence. Clause 133 would also:

- place several conditions on the Minister being allowed to do so, none of which would apply if the licensee agrees, in writing, to the cancellation; and
- state that the cancellation takes effect on the day the cancellation notice is given to the licensee or a later day stated in the notice.

134 Licence—emergency cancellation would permit the Minister to make an emergency cancellation of a licence, by written notice, so long as the Minister is satisfied on reasonable grounds that circumstances exist in relation to the licence that give rise to an immediate risk of harm to the health or safety of people to whom treatment, care or support is provided under the licence. Clause 134 would also specify:

- a number of matters which must be stated in the emergency cancellation notice; and
- that the cancellation takes effect on the day after the day the emergency cancellation notice is given to the licensee.

Part 13.3 Private psychiatric facilities—enforcement

135 Appointment of inspectors would permit the Director-General to appoint inspectors for this Chapter. Clause 135 would also compel such an inspector to exercise their functions under this Chapter, in accordance with the conditions of their appointment and any directions that the chief psychiatrist gives them.

135A Identity cards would compel the Director-General to give an inspector an identity card that states and shows certain items that clause 135A would specify.

Clause 135A would also declare that:

- it is an offence for a person who stops being an inspector to not return their identity card to the Director-General, as soon as practicable, but not later than 7 days, after the day the person stops being an inspector; and
- the maximum penalty for this offence is 1 penalty unit.

135B Powers of inspection would empower an inspector to enter licensed premises, at any reasonable time, and to do certain activities there that clause 135B would specify. These activities would include, but would not be limited to, requiring the occupier of the premises to give a copy of the records related to the conduct of the private psychiatric facility at the premises.

Clause 135B would place two qualifications on the exercise of these powers. They would be that if the inspector fails to show their identity card, when the occupier asks the inspector to do so:

- the inspector cannot remain on the premises; and
- the person is not required to give records to the inspector.

Finally, clause 135B would define occupier of licensed premises as including a person reasonably believed to be an occupier of the premises and a person apparently in charge of the licensed premises.

The privilege against self-incrimination, dealt with by section 170 of the Legislation Act, is relevant here.

135C Failing to comply with requirement of inspector would make it an offence for a person to not fulfill an inspector's requirement that the person give the inspector a copy of records, or access to records, under section 135B(1)(c). Clause 135C would also institute a maximum penalty for this offence of 50 penalty units.

Chapter 14 Mental health advisory council would contain sections 139 (Establishment of mental health advisory council) to 139C (Procedures of mental health advisory council) relocated from the amended Act, by *Mental Health Act 2015*, Schedule 2, Amendment 2.46. Schedule 2 contains no proposed amendments to sections 139 to 139C.

Chapter 15 Interstate application of mental health laws

Part 15.1 Preliminary

139CA Purpose—ch 15 would state four purposes for Chapter 15, namely:

- the apprehension of people subject to certain warrants or orders made in other states and territories of Australia, or who may otherwise be apprehended, under mental health legislation;
- the interstate transfer of people under such legislation;
- the treatment, care or support in the ACT of people subject to mental health orders or similar orders made in other states and territories of Australia; and
- the operation of certain mental health orders between the ACT and other states and territories, and vice versa.

139CB Definitions—ch 15 would state that for Chapter 15:

- ***authorised officer*** means an authorised ambulance paramedic; doctor; mental health officer; or police officer.
- ***community care service*** is a service that provides treatment, care or support for a person with a mental disorder living in the community.
- ***corresponding law*** means a law of another State that provides for the treatment, care or support of a person with a mental disorder or mental illness and includes a law of another State, including a law prescribed by regulation. Note that Part 1 of the Dictionary of the Legislation Act, provided by sections 2 and 144 of the Legislation Act, states that for ACT legislation '***State*** means a State of the Commonwealth, and includes the Northern Territory'.
- ***interstate authorised person*** is a person prescribed by regulation.
- ***interstate community care facility*** is a facility that, under a corresponding law, provides treatment, care or support for a person with a mental disorder.
- ***interstate community care service*** is a service that, under a corresponding law, provides treatment, care or support for a person with a mental disorder.
- ***interstate involuntary treatment order*** is an order made under a corresponding law for the involuntary treatment of a person with a mental disorder or mental illness at an interstate mental health facility or in the community.
- ***interstate mental health facility*** means a mental health facility in another State to which a person may be admitted under a corresponding law for treatment, care or support for mental illness.
- ***interstate mental health service*** is a service in another State that, under a corresponding law, provides treatment, care or support for a person with mental illness living in the community.
- ***interstate patient*** means a person subject to an interstate involuntary treatment order.
- ***mental health service*** is a service in the ACT that provides treatment, care or support for a person with mental illness who is living in the community.

139CC Authority to enter into agreements would authorise the Minister to enter into agreements with a Minister of another state or territory of Australia about any matter relating to the operation of Chapter 15 or a corresponding law. Clause 139CC would also stipulate that any such agreements will be notifiable instruments.

139CD Authorised officer and interstate authorised person may exercise certain functions would allow an authorised officer, or an interstate authorised person, to exercise any function conferred on the officer or person, under a corresponding law, or under an involuntary treatment order made in another state, in relation to an interstate patient in the ACT.

Clause 139CD would also supply a power to make regulations that impose limits on the people who may act under the clause and the treatment that may be given, or functions exercised, under it.

139CE Medication for person being transferred would allow a person being transferred under this Chapter to be given medication by an appropriately trained person, if they believe on reasonable grounds both that giving the medication is in the best interests of the safe and effective treatment, care or support of the person and that the medication has been prescribed by a doctor.

Clause 139CE would also require details about any medication given under this clause to be included in the person's record.

Part 15.2 Apprehension of people in breach of certain orders

139CF Apprehension of interstate patient in breach of interstate involuntary treatment order would permit an authorised officer or interstate authorised person to apprehend, in the ACT, an interstate patient in breach of an interstate involuntary treatment order, but only if:

- they would be subject to apprehension under a corresponding law of the State that issued their interstate involuntary treatment order, or
- a warrant or another document, issued under a corresponding law, authorises their apprehension.

Clause 139CF would also compel the apprehender to, as soon as reasonably practicable:

- tell the patient why they are being apprehended;
- ensure the patient has adequate opportunity and assistance to notify a relative or friend of the apprehension;
- tell an interstate mental health facility in the State that issued the interstate involuntary treatment order about the apprehension; and
- transfer the patient either to:
  - an ACT approved mental health facility to determine whether the patient requires treatment before being transferred; or
  - to an interstate mental health facility in the State that issued the patient's order.

Sections 139F (Powers of entry and apprehension) and 140 (Powers of search and seizure) would apply here.

139CG Apprehension of person in breach of mental health order or forensic mental health order would permit an authorised officer or interstate authorised person to apprehend an ACT patient, in another State, of an ACT patient in breach of a mental health order or forensic mental health order, so long as the ACT patient would be subject to apprehension, under this Act, if the patient were in the ACT and the apprehension is allowed under a corresponding law of the other State.

It would compel the apprehender to, as soon as reasonably practicable:

- tell the patient why they are being apprehended; and
- transfer the person either to an interstate mental health facility to determine whether the patient requires treatment before being transferred to an ACT approved mental health facility or community care facility.

Further, clause 139CG would require that, as soon as reasonably practicable after the ACT patient is transferred to an ACT facility, that the person in charge of that facility must:

- ensure that the patient has adequate opportunity and assistance to notify a relative or friend of the apprehension and transfer; and
- take all reasonable steps to tell at least 1 of a number of people clause 139CG lists.

Sections 139F (Powers of entry and apprehension) and 140 (Powers of search and seizure) would apply here.

Part 15.3 Transfer of certain people from ACT

139CH Interstate transfer—person under psychiatric treatment order or community care order would provide that the relevant person may apply to ACAT to subject a person to an interstate transfer order, if the person is:

- already subject to a psychiatric treatment order, or community care order; and
- receiving treatment, care or support under that order, in or from an approved mental health facility, a mental health service, an approved community care facility, or a community care service.

Clause 139CH would also state that the relevant person may only make this application, if the relevant person believes, on reasonable grounds, that ACAT could reasonably subject that person to an interstate transfer order under this clause. The relevant person would be the chief psychiatrist, in respect of a person subject to a psychiatric treatment order, and the care coordinator, in respect of a person subject to a community care order.

Clause 139CH would define ***interstate transfer order*** as an order to transfer:

- a person to an interstate mental health facility or an interstate community care facility; or
- the responsibility to provide treatment, care or support for a person to an interstate mental health service or interstate community care service.

Clause 139CH would compel ACAT to hear and decide such an application, as soon as practicable. It would also dictate that ACAT cannot make an interstate transfer order, unless it believes, on reasonable grounds, all of the following:

- it is in the best interests of the safe and effective treatment, care or support of the person; and
- the transfer is allowed under a corresponding law; and
- the person in charge of the interstate facility or service has agreed to the transfer.

Clause 139CH would require that in satisfying itself that it is in the best interests of the person, ACAT must take into account the person's views and wishes and, as far as practicable, the other persons that would be nominated in clause 139CH(4)(b).

Clause 139CH would mandate that if ACAT makes an order under clause 139CH, ACAT will:

- as soon as practicable, after making it, give a copy of the order to the person, the relevant person, and the person in charge of the relevant interstate facility or service; and
- as far as practicable, notify the people enumerated in subclause (4)(b).

Clause 139CH would permit an authorised officer, or an interstate authorised person, to take the subject person to the interstate facility or service.

Sections 139F (Powers of entry and apprehension) and 140 (Powers of search and seizure) would apply here.

139CI Interstate transfer—person under forensic psychiatric treatment order or forensic community care order would largely replicates the process provided by clause 139CH.

Clause 139CI would differ from clause 139CH in that clause 139CI would:

- enable an interstate transfer order to be made for a person who is subject to an ACT *forensic psychiatric treatment order* or *forensic community care order*; and
- require that ACAT, as far as practicable, consult with, and notify, certain people involved in serving persons who have become subject to bail and community-based sentences in the justice system.

As clause 139CH would also require, under clause 139CI, the person would have to be receiving treatment, care or support under the order, in an approved mental health facility, or from a mental health service, or in an approved community care facility, or from a community care service.

Clause 139CI would define ***interstate transfer order*** in the same way as clause 139CH would.

Clause 139CI would allow the relevant person to apply to ACAT to subject the person to an interstate transfer order, if the relevant person believes on reasonable grounds that ACAT could reasonably do so. The relevant person would be the chief psychiatrist, in respect of a person subject to a forensic mental health order, and the care coordinator, in respect of a person subject to a forensic community care order.

Clause 139CI would require ACAT to hear and decide such an application, as soon as practicable. It would also preclude ACAT making an interstate order, under clause 139CI, unless it believes, on reasonable grounds, all of the following:

- it is in the best interests of the safe and effective treatment, care or support of the person; and
- the transfer is allowed under a corresponding law; and
- the person in charge of the interstate facility or service has agreed to the transfer.

Clause 139CI would require ACAT to take into account the views and wishes of the person and, as far as practicable, of the other people that clause's subclause 4(b) would nominate, when it is satisfying itself that the interstate transfer order is in the person's best interests.

Clause 139CI would mandate that if ACAT makes an order under clause 139CI, ACAT will:

- as soon as practicable, after making it, give a copy of the order to the person, the relevant person, and the person in charge of the relevant interstate facility or service; and
- as far as practicable, notify the people that clause 139CI's subclause 4(b) would enumerate.

Clause 139CI would permit an authorised officer, or an interstate authorised person, to take the subject person to the interstate facility or service.

Sections 139F (Powers of entry and apprehension) and 140 (Powers of search and seizure) would apply here.

139CJ Transfer to interstate mental health facility—emergency detention
would permit the chief psychiatrist to direct a person's transfer to an interstate mental health facility, if the person is detained, and being assessed, or receiving treatment, care or support, under Chapter 6 (Emergency detention).

However, clause 139CJ would proscribe the chief psychiatrist making this direction, unless:

- the chief psychiatrist believes on reasonable grounds that the transfer is in the best interests of the safe and effective treatment, care or support of the person;[143] and
- such a transfer is allowed under a corresponding law; and
- the person in charge of the interstate mental health facility agrees to the transfer; and
- before giving the direction, the chief psychiatrist has, as far as practicable, notified certain people, who would be specified by subclause (3)(a), that a direction under this clause is being considered; and
- taken into account the views of those specified people, as far as practicable, as well as the person's views and wishes, in respect of the proposed direction.

Clause 139CJ would mandate that if the chief psychiatrist gives such a direction, under this clause, they will:

- as soon as practicable, after giving it, give a copy of it to the person, the relevant person, and the person in charge of the relevant interstate facility or service; and
- as far as practicable, notify the people enumerated in subclause (3)(a).

Clause 139CJ would permit an authorised officer, or an interstate authorised person, to take the subject person to the interstate facility or service.

Sections 139F (Powers of entry and apprehension) and 140 (Powers of search and seizure) would apply here.

[143] Both *LBH v Neary* (2011) England and Wales High Court 1377, and *A CC v MB* (2010) England and Wales High Court 2508, state that perfunctory best interests assessments are unlawful.

139CK Interstate transfer—when ACT order stops applying would state that a person stops being subject to a psychiatric treatment order, or a community care order, made under this Act, when the person, or responsibility for them, is transferred under this Part and the person is:

- admitted to an interstate mental health facility or an interstate community care facility; or
- accepted into the care of an interstate mental health or community care service; or
- made the subject of an interstate involuntary treatment order.

Part 15.4 Transfer of certain people to ACT

139CL Transfer of interstate patient to approved mental health facility would permit the chief psychiatrist for an interstate patient to transfer that patient to an approved mental health facility in the ACT, if the person is subject to an interstate involuntary treatment order that allows for detention at an interstate mental health facility. Clause 139CL would also allow the ACT chief psychiatrist to agree to the transfer, if the ACT chief psychiatrist believes, on reasonable grounds, that the interstate patient's transfer to the ACT is both:

- in the best interests of that patient's safe and effective treatment, care or support; and
- allowed under a corresponding law.

139CM Transfer of responsibility to provide treatment, care or support in the community for interstate patient would permit the chief psychiatrist for an interstate patient to transfer responsibility for that patient to the ACT chief psychiatrist, if the person is subject to an interstate involuntary treatment order that allows treatment in the community.

Clause 139CM would allow the ACT chief psychiatrist to agree to the transfer, if the ACT chief psychiatrist believes, on reasonable grounds, that the patient's transfer to the ACT is both:

- in the best interests of that patient's safe and effective treatment, care or support; and
- allowed under a corresponding law.

139CN Transfer of person apprehended in another State to approved mental health facility would permit an authorised officer, or an interstate authorised person, to take a person apprehended in another State, under a corresponding law, to an approved mental health facility in the ACT.

However, it would only so permit, if that authorised officer or person believes, on reasonable grounds, that taking the person to the ACT facility is both:

- in the best interests of the person's safe and effective treatment, care or support; and
- allowed under a corresponding law.

Clause 139CN would apply Chapter 6 (Emergency detention) to a person apprehended under this clause, as if the person had been apprehended under section 37 (Apprehension).

Sections 139F (Powers of entry and apprehension) and 140 (Powers of search and seizure) would also apply here.

Part 15.5 Interstate operation of certain orders

139CO Mental health order relating to interstate person would permit a person who does not usually live in the ACT to be subject to a mental health order, under this Act, but only if both of two conditions obtain. These conditions are that:

- the facility or service that is treating, caring for, or supporting, the person is located in the ACT; and
- the order is allowed under a corresponding law of the State in which the person usually lives.

Clause 139CO would impose one qualification on a restriction order mentioned in section 36X (Criteria for making restriction order with psychiatric treatment order) that is made for a person who does not usually live in the ACT. That qualification would be that the order may only impose restrictions on the person's actions within the ACT.

139CP Implementing interstate involuntary treatment order for temporary ACT resident would permit a person who is temporarily living in the ACT to be given treatment, care and support in the ACT, if they are subject to an interstate involuntary treatment order that makes provision for treatment, care or support in the community. However, clause 139CP would make this contingent on the ACT chief psychiatrist being satisfied, on reasonable grounds, that:

- the person has a 'mental illness', a term defined in section 10 of the Act; and
- the person accepts the treatment, care or support; and
- that treatment, care or support in the ACT is in the person's best interests and it is expected to be needed for a period not exceeding 4 weeks at a time.

Clause 139CP would allow treatment, care or support to be given by:

- an authorised officer, if they are permitted to do so under a corresponding law of the State that issued the interstate involuntary treatment order; or
- an interstate authorised person.

Chapter 16 Notification and review of decisions would contain sections 139CR (Meaning of reviewable decision) to 139CT (Applications for review) relocated from the amended Act, by *Mental Health Act 2015*, Schedule 2, Amendment 2.47.

Chapter 17 Miscellaneous would contain sections 139D (Approval of mental health facilities) to 147 (Regulation making power), relocated from the amended Act, by *Mental Health Act 2015*, Schedule 2, Amendment 2.48.

Mental Health Act 2015, Schedule 2, Amendments 2.29 to 2.32, would also respectively:

- amend sections 139F(1)(e) and (f);
- insert new section 139F(1)(l) to (q);
- insert new section 140(1)(o) to (t); and
- insert new section 140AA.

Chapter 18 Repeals and consequential amendment would supply two clauses:

- one that would repeal the current Act and legislative instruments under it, bar the interstate agreements, because the Bill, if enacted, will be the *Mental Health Act 2015*, and new legislative instruments will be made under that Act; and
- a second that would make the amendments to legislation that are specified in Bill Schedule 2.

These amendments are to:

- the *Mental Health (Treatment and Care) Act 1994*, as amended by the Amendment Act;
- several Acts, apart from the *Mental Health (Treatment and Care) Act 1994*; and
- several Regulations.

All of these amendments would be necessitated by how these Acts and Regulations would interact with the proposed *Mental Health Act 2015*.

Chapter 40 Transitional

Part 40.1 General

400 Definitions—ch 40 would define, for this Chapter:

- ***commencement day*** as 'the day this chapter commences'; and
- ***repealed Act*** as 'the Mental Health (Treatment and Care) Act 1994 as in force immediately before the commencement day'.

401 Transitional regulations would empower the making of regulations that prescribe transitional matters that would be necessary, as a consequence of the Amendment Act or the *Mental Health Act 2015*. Clause 401 would also:

- permit a regulation to modify Chapter 40, including in relation to another ACT law, to make provision for anything that is not, or is not adequately or appropriately, dealt with by this Chapter.
- state that a regulation that modifies this Chapter has effect despite anything elsewhere in the *Mental Health Act 2015*.

402 Expiry—ch 40 would make Chapter 40 (Transitional) expire two years after the 'commencement day', as defined at the beginning of the Chapter.

As per section 88 of the Legislation Act, transitional provisions repealed on its expiry, but continues to have effect after its repeal.

Part 40.2 Transitional—rights of people with mental disorder or mental illness

403 Rights in relation to information and communication would put beyond doubt that the responsible person for a facility must comply with section 15 (Information to be given to people) in relation to a person receiving treatment, care or support at the facility, even if they began receiving that there, before the commencement day.

Note that 'responsible person', here, has the same meaning as that given to this term by section 14 of the amended Act, which provides that the responsible person is the:

- facility owner, for a mental health facility not conducted by the Territory;
- chief psychiatrist, for a psychiatric facility conducted by the Territory; and
- director-general of the administrative unit responsible for the conduct of the facility.

Part 40.3 Transitional—mental health orders

Division 40.3.1 Applications

404 Application by person with mental illness or mental dysfunction—unfinished applications would be about what would occur if a mental health order application is made under the repealed Act's section 10 (Application by mentally dysfunctional or mentally ill people) and the application is not decided by ACAT before commencement day.

Clause 404 would provide that such an application is to be dealt with as an assessment order application, under section 33 (Applications by people with mental disorder or mental illness—assessment order).

405 Application by chief psychiatrist or care coordinator—unfinished applications would be about what would occur if, before commencement day, the chief psychiatrist or care coordinator applies for a mental health order, under the repealed Act's section 11 (Applications by other people), and ACAT has not decided that application before commencement day.

Clause 405 would state that such an application it is to be dealt with as one that was made under section 36O (Applications for mental health orders).

406 Application by certain other people—unfinished applications would be about what would occur if, before commencement day, a person, other than the chief psychiatrist or the care coordinator, makes a mental health order application, under the repealed Act's section 11 (Applications by other people) and ACAT has not decided the application.

Clause 406 would state that such an application must be dealt with as an assessment order application, under section 34 (Applications by other people—assessment order).

407 Application by referring officers—unfinished referrals would declare that, if before commencement day, ACAT has not decided a referral to it for a mental health order, made under the repealed Act's section 13 (Referrals to ACAT), the referral is to be dealt with as an assessment order application, under section 35 (Applications by referring officers—assessment order).

Division 40.3.2 Psychiatric treatment orders

408 Psychiatric treatment order—in force before commencement day would be about a person who is subject to a psychiatric treatment order under the repealed Act's section 28 (Criteria for making psychiatric treatment order), immediately before commencement day.

Clause 408 would state that, on and after commencement day, such an order is to be dealt with, in accordance with its particular terms, as an order under section 36V (Psychiatric treatment order).

409 Restriction order with psychiatric treatment order—in force before commencement day would be about a person who is subject to a restriction order, under the repealed Act's section 30 (Criteria for making restriction order with psychiatric treatment order), immediately before commencement day.

Clause 409 would state that on and after commencement day, that order is to be dealt with, in accordance with its particular terms, as a restriction order under section 36X (Criteria for making restriction order with psychiatric treatment order).

410 Chief psychiatrist role—determination in force before commencement day would be about a person subject to a psychiatric treatment order, under the repealed Act's section 28 (Criteria for making psychiatric treatment order), and a determination, under the repealed Act's section 32 (Role of chief psychiatrist), immediately before commencement day.

Clause 410 would state that on and after commencement day, the determination is to be dealt with, in accordance with its particular terms, and as a determination under Bill section 36Z (Role of chief psychiatrist—psychiatric treatment order).

411 Action if psychiatric treatment order no longer appropriate—notice given but not considered by ACAT would state that a notice given under the repealed Act's section 34 (Action if psychiatric treatment order no longer appropriate) ceases to have effect, if:

- before commencement day, the chief psychiatrist has given notice, under section 34, on a person's psychiatric treatment order; and
- immediately before commencement day, ACAT has not finalised that order's review, under the repealed Act's section 36L (Review, variation and revocation of orders).

Clause 411 would also state that, as soon as practicable after commencement day, the chief psychiatrist must give notice about the person's psychiatric treatment order, under section 36ZB (Action if psychiatric treatment order no longer appropriate—no longer person in relation to whom ACAT could make order).

Division 40.3.3 Community care orders

412 Community care order—in force before commencement day would state that, if immediately before commencement day, a person is subject to a community care order, under the repealed Act's section 36 (Criteria for making community care order), then, on and after commencement day, that order is to be dealt with, in accordance with its particular terms, and as an order under section 36ZD (Community care order).

413 Restriction order with community care order—in force before commencement day would state that if, immediately before commencement day, a person is subject to a restriction order under the repealed Act's section 36B (Criteria for making restriction order with community care order), then, on and after commencement day, the restriction order is to be dealt with, in accordance with its particular terms, and as a restriction order under section 36ZF (Criteria for making restriction order with community care order).

414 Care coordinator role—determination in force before commencement day would state that if, immediately before commencement day, a person is subject to a community care order and is also subject to a determination under the repealed Act's section 36D (Role of care coordinator), then, on and after commencement day, the determination is to be dealt with, in accordance with its particular terms, and as a determination under Bill section 36ZH (Role of care coordinator—community care order).

415 Action if community care order no longer appropriate—notice given but not considered by ACAT would state that on commencement day, a notice given under the repealed Act's section 36F (Action if community care order no longer appropriate) ceases to have effect, if:

- before commencement day, the care coordinator has given notice under section 36F; and
- immediately before commencement day, ACAT has not finalised the order's review under the repealed Act's section 36L (Review, variation and revocation of orders).

Clause 415 would also dictate that, as soon as practicable after commencement day, the care coordinator must give notice about the person's community care order, under section 36ZJ (Action if community care order no longer appropriate—no longer person in relation to whom ACAT could make order).

Division 40.3.5 Other matters

416 Forensic mental health orders—people required to submit to ACAT jurisdiction before commencement day would be about a person who a court required, before commencement day, to submit to ACAT's jurisdiction, under Part 13 (Unfitness to plead and mental impairment) of the ACT Crimes Act, or Part 1B (Sentencing, imprisonment and release of federal offenders) of the *Crimes Act 1914* (Cwlth).

Clause 416 would remove any doubt that sections 48ZA (Forensic psychiatric treatment order) and 48ZH (Forensic community care order) apply in relation to such a person.

Part 40.4 Transitional—emergency detention

417 Apprehension before commencement day would state that if, before commencement day, a person is apprehended under the repealed Act's section 37 (Apprehension), then on and after commencement day, the apprehension is taken to be an apprehension under section 37 (Apprehension).

418 Authorisation of involuntary detention before commencement day would be about a person who is involuntarily detained at an approved mental health facility, under an authorisation under the repealed Act's section 41(1) (Authorisation of involuntary detention).

Clause 418 would state that if the person is so detained, before commencement day, then, on and after commencement day, then the authorisation under the repealed Act is to be dealt with, in accordance with its particular terms, and as an authorisation under section 41(1) (Authorisation of involuntary detention).

Clause 418 would also provide for when, before commencement day, an application for further detention has been made under the repealed Act's section 41(2)(b) (Authorisation of involuntary detention), and, immediately before commencement day, ACAT has not decided the application. Clause 418 would state that, on and after commencement day, such an application is to be dealt with as an application under section 41(2) (Authorisation of involuntary detention).

Finally, clause 418 would provide for when, before commencement day, ACAT orders a further period of involuntary detention under the repealed Act's section 41(2) (Authorisation of involuntary detention). Clause 418 would state that, on and after commencement day, such an order is to be dealt with, in accordance with its particular terms, as an order under section 41(3) (Authorisation of involuntary detention).

Part 40.5 Transitional—interstate application of mental health laws

419 Interstate agreements notified before commencement day would state that the following instruments are to be taken as entered into, and notified under, clause 139CC (Authority to enter into agreements):

- *Mental Health (Treatment and Care) (Interstate Application of Mental Health Laws) Agreement 2002 (No 1)* (NI2002-405);
- *Mental Health (Treatment and Care) (Interstate Application of Mental Health Laws) Agreement 2002 (No 2)* (NI2002-406);
- *Mental Health (Treatment and Care) (Interstate Application of Mental Health Laws) Agreement 2003* (NI2003-523);
- *Mental Health (Treatment and Care) (Interstate Application of Mental Health Laws) Agreement 2004* (NI2004-500); and
- *Mental Health (Treatment and Care) Interstate Application of Mental Health Laws Agreement 2011* (NI2011-196).

These instruments were originally entered into, and notified, under section 48C of the repealed Act.

Schedule 1 Reviewable decisions

Schedule 2, Amendment 2.47 would relocate, into Chapter 16, sections 139CR (Meaning of *reviewable decision* – ch 16), 139CS (Reviewable decision notices), and 139CT (Applications for review), all of which refer to 'Schedule 1 Reviewable decisions'.

Schedule 1 (Reviewable decisions) provides a table of the:

- decisions that section 139CR would make reviewable;
- persons that section 139CS would require to be given a reviewable decision notice; and
- persons that section 139CT would empower to apply to ACAT for review of a reviewable decision.

In the case of each reviewable decision provided by these three sections and Schedule 1, the *Mental Health Act 2015* would require a reviewable decision notice to be given to the person who that Act would permit to apply to ACAT for the decision's review.

Schedule 1 lays this out in a table, which enumerates the following:

- The applicant for leave is the person who would be able to apply to ACAT for review of a decision to refuse to grant leave, made under section 48ZU (Grant of leave for person detained by relevant official). Bill Schedule 2, Amendment 2.41, would relocate section 48ZU into Chapter 7 (Forensic mental health).
- The applicant for leave is the person who would be able to apply to ACAT for review of a decision to refuse to grant leave, made under section 48ZV (Leave in emergency or special circumstances). Bill Schedule 2, Amendment 2.41, would relocate section 48ZV into Chapter 7 (Forensic mental health).
- The applicant for leave is the person who would be able to apply to ACAT for review of the decision to revoke leave, made under section 48ZW (Revocation of leave granted by relevant official). Bill Schedule 2, Amendment 2.41, would relocate section 48ZW into Chapter 7 (Forensic mental health).
- The applicant for leave is the person who would be able to apply to ACAT for review of the decision to refuse to grant leave, made under section 48ZZQ (Grant of leave for correctional patients). Bill Schedule 2, Amendment 2.42, would relocate section 48ZZQ into Chapter 8 (Correctional patients).
- The applicant for leave is the person who would be able to apply to ACAT for review of the decision to revoke leave, made under section 48ZZR (Revocation of leave for correctional patients). Bill Schedule 2, Amendment 2.42, would relocate section 48ZZR into Chapter 8 (Correctional patients).
- The applicant for the licence is the person who would be able to apply to ACAT for review of the decision to refuse to issue a licence, made under clause 127 (Licence – decision on application), in Bill Chapter 13 (Private psychiatric facilities).
- The applicant for renewal of the licence is the person who would be able to apply to ACAT for review of the decision to refuse to renew a licence, made under clause 128 (Licence – term and renewal of licence), in Bill Chapter 13 (Private psychiatric facilities).
- The licensee and the proposed new licensee are the persons who would be able to apply to ACAT for review of the decisions to refuse to transfer a licence, made under clause 129 (Licence – transfer of licence), in Bill Chapter 13 (Private psychiatric facilities).
- The licensee is the person who would be able to apply to ACAT for review of the decision to amend a licence, made under clause 130 (Licence – amendment initiated by Minister), in Bill Chapter 13 (Private psychiatric facilities).
- The licensee is the person who would be able to apply to ACAT for review of the decision to refuse to amend a licence, made under clause 131 (Licence – amendment on application by licensee), in Bill Chapter 13 (Private psychiatric facilities).
- The licensee is the person who would be able to apply to ACAT for review of the decision to cancel a licence, made under clause 133 (Licence – cancellation by notice), in Bill Chapter 13 (Private psychiatric facilities).
- The licensee is the person who would be able to apply to ACAT for review of the decision to cancel a licence, made under clause 134 (Licence – emergency cancellation), in Bill Chapter 13 (Private psychiatric facilities).

Schedule 2 Legislation amended

Part 2.1 Mental Health (Treatment and Care) Act 1994

Division 2.1.1 Amendments

[2.1] Section 15 (1) (b) (vi) would omit this section from the current Act.

[2.2] New section 15(4)(g) would insert '(g) if the person has a carer—the carer' into the list of persons to whom the responsible person for a mental health facility or community care facility, or mental health professional, must take reasonable steps to give a copy of the information required by 15(1)(b) (Information to be given to people).

[2.3] Section 27 (4) and note would respectively add:

- that an advance consent direction, which gives advance consent for ECT, must state the maximum number of times, not exceeding 9 times, that ECT may be administered to the person under that consent; and
- a note that if a form is approved under section 146A for this provision, the form must be used.

[2.4] Section 36H would state that as well as a police officer, an authorised ambulance paramedic, doctor or mental health officer may execute a removal order in relation to a person, under section 36G(2). The current section 36G(2) only permits a police officer to execute a removal order.

[2.5] Section 36M(2) would correct a grammatical error, by omitting 'ACAT, must' and substituting it with 'ACAT must,'.

[2.6] Section 36R(1)(g) would insert 'parole or' before 'licence', so that ACAT would be required to consult, as far as practicable, with the corrections director-general, before ACAT makes a mental health order in relation to a person who is on parole.

[2.7] Section 36R(1)(h) would remove the erroneous, redundant article 'a', from section 36R(1)(h).

[2.8] Section 36R(2) would replace 'if the ACAT has contact details for the carer' with 'as far as practicable'. The outcome of this would be that ACAT would be required to, as far as practicable consult with a person's carer, before making a mental health order in relation to the person, rather than this consultation being contingent on ACAT having the carer's 'contact details'.

[2.9] Section 36Z(5)(a)(viii) would insert 'parole or' before 'licence'. The outcome of this would be that section 36Z(5)(a)(viii) would newly require the chief psychiatrist to consult with the corrections director-general, as far as practicable, before the chief psychiatrist makes a determination in relation to a person who is subject to a psychiatric treatment order and on parole.

[2.10] Section 36ZC(5) would omit all instances of 'confinement or', from this provision, as they are errors.

[2.11] Section 36ZH(3)(a)(viii) would insert 'parole or' before 'licence', so that the section would newly require the care coordinator to consult with the corrections director-general, as far as practicable, before the care coordinator makes a determination in relation to a person who is subject to a community care order and on parole.

[2.12] Section 36ZK(5) would omit all instances of 'confinement or', from this section, as they are errors.

[2.13] Section 42(2) would omit 'at least 1 of' from this section. It would do so,

because it is not in a person's interests, for a doctor or mental health officer to advise that a person has been involuntarily detained under sections 38 or 41, and where and why they have been detained, to say, the person's nominated person, but not the person's parent, if the person is a child, or the person's nominated person, but not their guardian, if the person has a guardian, and so on.

[2.14] Sections 42(3) and (4) would newly require:

- ACAT to take all reasonable steps to give the name of the person, and where the person is being detained and why, to the people mentioned in subsections (2)(a) to (e), as soon as practicable after ACAT orders under section 41(3) that a period of involuntary detention be extended.
- the doctor or mental health officer to advise the public advocate, if the doctor or mental health officer were unable to give the name of the detained person, where they are being detained, and why, to anyone connected to the person.
- the doctor or mental health officer to advise the public advocate, if the doctor or mental health officer were unable to give the name of the detained person, where they are being detained, and why, to:
  - a person with parental responsibility for the detained person, if the latter is a child, and who the information on that child was given to, if anyone;
  - the detained person's guardian under the *Guardianship and Management of Property Act 1991*, if the detained person has a guardian, and who the information on that detained person was given to, if anyone; and
  - the detained person's enduring power of attorney under the *Powers of Attorney Act 2006*, if the detained person appears to have impaired decision-making capacity within the meaning of that Act, and who the information on that detained person was given to, if anyone.

[2.15] Section 48S, definition of *community-based sentence* would omit this definition, as it is now in the Bill Dictionary, which is supplied by Bill clause 3.

[2.16] Section 48T heading would shorten the section 48T heading 'Applications for forensic mental health orders—detainees and people under community-based sentences' to 'Applications for forensic mental health orders—detainees etc'.

[2.17] Section 48T(1) and (2) would be comprised of two subsections.

Subsection (1) would extend the application of section 48T from only people on community based sentences to people on those sentences, as well as people released on parole or on licence, under section 299 of the *Crimes (Sentence Administration) Act 2005*, and to young detainees and offenders.

Subsection (2) would make the relevant person applying to ACAT for a forensic mental health order in relation to a person contingent on the relevant person believing, on reasonable grounds, that the subject person is someone in relation to whom ACAT could reasonably make an order under sections 48ZA (Forensic psychiatric treatment order) or 48ZH (Forensic community care order). This threshold test in not in the current section 48T(2).

[2.18] Section 48Y(1)(b) would remove the requirement, from this section, that ACAT consider '(b) whether the person consents, refuses to consent or has the decision-making capacity to consent, to proposed treatment, care or support', in making a person subject to a forensic mental health order.

[2.19] Section 48ZA(1)(b) would extend the application of section 48ZA(1)(b) from only persons subject to community based orders who are referred to ACAT for

a forensic mental health order under division 7.1.2 to everyone who is referred to ACAT for a forensic mental health order. This would correct an error issuing from the Amendment Act.

[2.20] Section 48ZC(6)(a)(vii) would insert 'parole or' before 'licence', so that the section would newly require the chief psychiatrist to consult with the corrections director-general, as far as practicable, before the chief psychiatrist makes a determination in relation to a person who is both subject to a forensic psychiatric treatment order and on parole.

[2.21] Section 48ZG(5) would omit all instances of 'confinement or', from this provision, as they are errors.

[2.22] Section 48ZH(1)(b) would extend the application of section 48ZH(1)(b) from only people on a community based order referred to ACAT for a forensic mental health order under division 7.1.2 to anyone so referred. This would correct an error issuing from the Amendment Act.

[2.23] Section 48ZJ(4)(a)(vii) would insert 'parole or' before 'licence', so that the section would newly require the care coordinator to consult with the corrections director-general, as far as practicable, before the chief psychiatrist makes a determination in relation to a person who is subject to a forensic community care order and on parole.

[2.24] Section 48ZN(5) would omit all instances of 'confinement or', from this provision, as they are errors.

[2.25] New section 72(6) would insert subsection (6) into section 72 to ensure that ACAT, as far as practicable, advises a list of people specified in subsection (6) that a person's detention, initiated by a court order under Part 13 of the Crimes Act, has been continued, because ACAT has decided to continue it, on reviewing that detention, as required by subsection (2).

Section 72 of the amended Act will make certain requirements, and give certain permissions, in respect of ACAT periodically reviewing:

- a court order, under the Crimes Act, Part 13 (Unfitness to plead and mental impairment), that requires a person to be detained in custody until ACAT orders otherwise; or
- an ACAT order requiring a person to be detained in custody under the Act's section 74 (Breach of conditions of release).

[2.26] Section 78(1)(g) and (h) would replace paragraphs (g) and (h) of section 78(1) with: '(g) an ECT order under section 55G (Making of electroconvulsive therapy order);

(h) an emergency ECT order under section 55K (Making of emergency electroconvulsive therapy order);'.

This change would align this section's mentions of ECT clauses with how those ECT clauses now read in this Bill.

[2.27] Section 79A(3)(e) would replace paragraph (e) of section 79A(3) with: '(e) the making of an emergency ECT order under section 55K (Making of emergency electroconvulsive therapy order);'.

Again, this change would align this section's mentions of ECT clauses with how those ECT clauses now read in this Bill.

[2.28] Section 87(1)(ga) would extend the coverage of paragraph (ga) to all people who are now covered by section 48T, rather than only people on community-based sentences. For more on this, see Amendment 2.17 to section 48T, above.

[2.29] Section 139F(1)(e) and (f) would remove '(e) section 48ZG (Powers in relation to forensic psychiatric treatment order)' and '(f) section 48ZN (Powers in relation to forensic community care order)' from the list of powers to which the section 139F powers of entry and apprehension would apply. It would so remove sections 48ZG and 48ZN, because they do not need to be in this section 139F list.

For a person subject to a forensic psychiatric treatment order, the chief psychiatrist will have determined whether the person:

- may live in the community and, if so, when and where they will attend to receive treatment, care and support; or
- must be admitted to an approved mental health facility, and, if so, whether the person is permitted to have leave from the facility.

That is because the chief psychiatrist is required to do so, under section 48ZC(2) (Role of chief psychiatrist – forensic psychiatrist treatment order).

Similarly, for a person subject to a forensic community care order, the care coordinator will have determined when and where the person is required to attend to receive treatment care or support or undertake a counseling, training, therapeutic or rehabilitation program. That is because the care coordinator is required to so, by section 48ZJ(2).

Accordingly, the section 139F powers of entry and apprehension will not need to be used in respect of persons subject to forensic psychiatric treatment or community care orders, because they will be:

- in attendance at treatment; or
- absconding from a facility, in which case an authorised person can rely on the section 48ZY (Contravention of forensic mental health order – absconding from a facility) to apprehend, remove and take the person to a facility, and section 48ZY is already listed in section 139F(1); or
- in the community contravening their order, in which case an authorised person can rely on the section 48ZX (Contravention of forensic mental health order) to apprehend, remove and take the person to a facility and section 48ZX is already listed in section 139F(1).

[2.30] New section 139F(1)(l) to (q) would extend the section 139F powers of entry and apprehension, and its safeguards on those powers, to exercises of functions under the following clauses:

- 139CF (Apprehension of interstate patient in breach of interstate involuntary treatment order);
- 139CG (Apprehension of person in breach of mental health order or forensic mental health order);
- 139CH (Interstate transfer—person under psychiatric treatment order or community care order);

- 139CI (Interstate transfer—person under forensic psychiatric treatment order or forensic community care order);
- 139CJ (Transfer to interstate mental health facility— emergency detention); and
- 139CN (Transfer of person apprehended in another State to approved mental health facility).

[2.31] New section 140(1)(o) to (t) would extend the section 140 powers of search and seizure, and its safeguards, to the exercise of functions under these clauses:

- 139CF (Apprehension of interstate patient in breach of interstate involuntary treatment order);
- 139CG (Apprehension of person in breach of mental health order or forensic mental health order);
- 139CH (Interstate transfer—person under psychiatric treatment order or community care order);
- 139CI (Interstate transfer—person under forensic psychiatric treatment order or forensic community care order);
- 139CJ (Transfer to interstate mental health facility— emergency detention);
- 139CN (Transfer of person apprehended in another State to approved mental health facility).
- 48ZN (Powers in relation to forensic community care order);
- 48ZT (Revocation of leave granted by ACAT); and
- 48ZW (Revocation of leave granted by relevant official).

[2.32] New section 140AA would insert a new section 140AA entitled 'Report and record of use of restraint etc'. This new provision would require an authorised person who exercises a power under sections 139F or 140 to take a person to a facility to report to the person in charge of the facility, if, in the course of exercising the power the authorised person—

- restrains, involuntary secludes or forcibly gives medication to the subject person; or
- becomes aware of anything else that may have an adverse effect on the subject person's physical or mental health.

New section 140AA would compel the person in charge of the facility to:

- enter the report in the subject person's record; and
- keep a register of any restraint, involuntary seclusion or forcible giving of medication included in the report, if the facility is a community care facility or mental health facility.

New section 140AA would also state that for the purposes of interpreting that section:

- ***facility*** means a community care facility, mental health facility and an interstate facility; and
- ***interstate facility*** means an interstate community care facility and an interstate mental health facility under cChapter 15 (Interstate application of mental health laws).

Division 2.1.2 Relocations

[2.33] This amendment would relocate sections 5 to 13, inclusive, of the amended Act, into Chapter 2 (Objects and important concepts).

[2.34] This amendment would relocate sections 14 to 32, inclusive, of the amended Act, into Chapter 3 (Rights of people with mental disorder or mental illness).

[2.35] This amendment would relocate sections 33 to 36, inclusive, and 36A to 36M of the amended Act, into Chapter 4 (Assessments).

[2.36] This amendment would relocate sections 36N to 36ZQ, inclusive, of the amended Act, into Chapter 5 (Mental Health Orders).

[2.37] This amendment would relocate sections 37, 38, and 38A of the amended Act, into Chapter 6 (Emergency Detention).

[2.38] This amendment would relocate sections 40, 41, and 41AA of the amended Act, into Bill Chapter 6 (Emergency Detention).

[2.39] This amendment would relocate section 42 of the amended Act, into Chapter 6 (Emergency Detention).

[2.40] This amendment would relocate section 45 of the amended Act, into Chapter 6 (Emergency Detention).

[2.41] This amendment would relocate sections 48S to 48ZZH, inclusive, of the amended Act, into Chapter 7 (Forensic mental health).

[2.42] This amendment would relocate sections 48ZZI to 48ZZR, inclusive, of the amended Act, into Chapter 8 (Correctional patients).

[2.43] This amendment would relocate sections 68 to 75, inclusive, of the amended Act, into Chapter 10 (Referrals by courts under Crimes Act and Children and Young People Act).

[2.44] This amendment would relocate sections 76 to 87, inclusive, of the amended Act, into Chapter 11 (ACAT procedural matters).

[2.45] This amendment would relocate sections 112 to 122J, inclusive, of the amended Act, into Chapter 12 (Administration).

[2.46] This amendment would relocate sections 139 to 139C, inclusive, of the amended Act, into Chapter 14 (Mental health advisory council).

[2.47] This amendment would relocate sections 139CR to 139CT, inclusive, of the amended Act, into Chapter 16 (Notification and review of decisions).

[2.48] This amendment would relocate sections 139D to 147, inclusive, of the amended Act into Chapter 17 (Miscellaneous).

Part 2.2 Mental Health Act 2015

[2.49] Act—renumbering would provide for the renumbering of provisions in the *Mental Health Act 2015*, when it is next republished under the Legislation Act.

Part 2.3 Other legislation

Division 2.3.1 Bail Act 1992

[2.50] Section 2, note 1 would substitute a note that uses ‘bail order’, as an example of a ‘signpost definition’, for a note that uses ‘mental dysfunction’ as a ‘signpost definition’ example. The term ‘mental dysfunction’ will no longer be used in this Act or other ACT statutes, including the enactment of Bill. Instead the term ‘mental disorder’, will be used.

Division 2.3.2 Children and Young People Act 2008

[2.51] Section 491, definition of *ACAT mental health provision* would replace 'has a mental illness or mental dysfunction', in this section, with 'has a mental disorder or mental illness'.

[2.52] Section 545 would replace 'is suffering from a mental illness or mental dysfunction', in this section, with 'has a mental disorder or mental illness'.

[2.53] Section 545, note would replace 'is not suffering from a mental illness or mental dysfunction', in this section, with 'does not have a mental disorder or mental illness'.

[2.54] Section 549(e)(i) would substitute 'is not suffering from a mental illness or mental dysfunction', in this section, with '(i) does not have a mental disorder or mental illness; or'.

[2.55] Section 549(e)(ii) and note would replace 'is suffering from a mental illness or mental dysfunction', in this section, with 'has a mental disorder or mental illness'.

[2.56] Section 562(1)(d) would replace 'is suffering from a mental illness or mental dysfunction', in this section, with 'has a mental disorder or mental illness'.

[2.57] Dictionary, new definition of *mental disorder* would insert the new definition '***mental disorder***—see the *Mental Health Act 2015*, section 9' into the Dictionary.

[2.58] Dictionary, definition of *mental dysfunction* would remove this definition from the Dictionary.

[2.59] Further amendments would replace '*Mental Health (Treatment and Care) Act 1994*' with '*Mental Health Act 2015*' in:

- the Note on section 161(2);
- section 186(8) definition of *relevant director-general*;
- section 530(1); and
- section 863(2).

Division 2.3.3 Coroners Act 1997

[2.60] Section 3C(1)(d) would replace '*Mental Health (Treatment and Care) Act 1994*', in this section, with '*Mental Health Act 2015*'.

[2.61] Dictionary, definitions of *chief psychiatrist* and *mental health officer* would replace '*Mental Health (Treatment and Care) Act 1994*', in these two definitions, with '*Mental Health Act 2015*'.

Division 2.3.4 Corrections Management Act 2007

[2.62] Section 54A etc would replace '*Mental Health (Treatment and Care) Act 1994*' with '*Mental Health Act 2015*' in:

- section 54A (Transfer to mental health facility—transfer direction);
- Note 2 on section 68(3) (Health assessment); and
- section 77(8) (Health reports), definition of relevant director-general.

Division 2.3.5 Court Procedures Act 2004

[2.63] Section 15(2)(c) would replace '*Mental Health (Treatment and Care) Act 1994*', in this section, with '*Mental Health Act 2015*'.

Division 2.3.6 Crimes Act 1900

[2.64] Section 300(1) etc would replace '*Mental Health (Treatment and Care) Act 1994*' with '*Mental Health Act 2015*' in all of the following sections of the *Crimes Act 1900* (ACT):

- 300(1) (Definitions for pt 13);
- 309(4) (Assessment whether emergency detention required);
- 318(2) (Non-acquittal at special hearing—non-serious offence);
- 319(2) (Non-acquittal at special hearing—serious offence);
- 323(3) (Supreme Court orders following special verdict of not guilty because of mental impairment—non-serious offence);
- 324(2) (Supreme Court orders following special verdict of not guilty because of mental impairment—serious offence);
- 328(3) (Magistrates Court orders following finding of not guilty because of mental impairment—non-serious offence); and
- 329(2) (Magistrates Court orders following finding of not guilty because of mental impairment—serious offence).

[2.65] Section 334(3)(d) would replace section 334(3)(d) with '(d) whether ACAT could make an order under the *Mental Health Act 2015*, section 48ZA (Forensic psychiatric treatment order) or section 48ZH (Forensic community care order); and'.

[2.66] Section 335A(1) would replace '*Mental Health (Treatment and Care) Act 1994*, s 68', in this section, with '*Mental Health Act 2015*, s 68'.

Division 2.3.7 Crimes (Child Sex Offenders) Regulation 2005

[2.67] Section 12(1)(d)(ii) would replace '*Mental Health (Treatment and Care) Act 1994*', in this section, with '*Mental Health Act 2015*'.

Division 2.3.8 Crimes (Sentence Administration) Act 2005

[2.68] Sections 57A(1)(b) and 92(3)(b)(ii) would replace '*Mental Health (Treatment and Care) Act 1994*', in this section, with '*Mental Health Act 2015*'.

[2.69] Section 321AA would replace 'a detainee', in this section, with 'a detainee, a person released on parole, a person released on licence or'.

[2.70] Section 321AA(2) would replace '*Mental Health (Treatment and Care) Act 1994*', in this section, with '*Mental Health Act 2015*'.

Division 2.3.9 Criminal Code 2002

[2.71] Section 712A (5), definition of *childrens proceeding* would replace '*Mental Health (Treatment and Care) Act 1994*', in this definition, with '*Mental Health Act 2015*'.

Division 2.3.10 Guardianship and Management of Property Act 1991

[2.72] Section 7(3) etc would replace '*Mental Health (Treatment and Care) Act 1994*' with '*Mental Health Act 2015*', in sections 7(3), 19 (2A), 32A, 32D, 32J(1), 32JA(1), and 70A.

[2.73] Dictionary, definitions of *electroconvulsive therapy, mental illness* and *psychiatric surgery* would respectively substitute those three definitions with:

- ***electroconvulsive therapy***—see the *Mental Health Act 2015*, section 49.
- ***mental illness***—see the *Mental Health Act 2015*, section 10.
- ***psychiatric surgery***—see the *Mental Health Act 2015*, section 49.

Division 2.3.11 Medicines, Poisons and Therapeutic Goods Regulation 2008

[2.74] Schedule 3, part 3.2, item 3, column 2 would replace '*Mental Health (Treatment and Care) Act 1994*', with '*Mental Health Act 2015*', in part 3.2, item 3, column 2 of the Schedule.

Division 2.3.12 Official Visitor Act 2012

[2.75] Section 7(e) etc would replace '*Mental Health (Treatment and Care) Act 1994*' with '*Mental Health Act 2015*' in:

- section 7(e);
- section 10(1)(e); and
- section 50, definition of ***operational Act***, paragraph (c).

[2.76] New part 11 would supply a new Part 11 entitled 'Transitional—Mental Health Act 2015' to continue the appointment of a person under section 10(1)(e) as an official visitor for the repealed *Mental Health (Treatment and Care) Act 1994*, if the appointment is in force immediately before the day that section 3 of the *Mental Health Act 2015* commences.

This amendment clause would save the appointee, under section 10(1)(e), as an official visitor for the *Mental Health Act 2015*, on the same conditions that applied to the person's appointment, immediately before the commencement day.

This amendment clause would also sunset the whole of new Part 11, six months after the day that section 3 of the *Mental Health Act 2015* commences.

Under section 88 of the Legislation Act, this transitional provision is repealed on its expiry, but continues to have effect.

Division 2.3.13 Planning and Development Act 2007

[2.77] Section 85A, definition of *mental health facility* would replace '*Mental Health (Treatment and Care) Act 1994*', in this definition, with '*Mental Health Act 2015*'.

Division 2.3.14 Powers of Attorney Act 2006

[2.78] Section 37 (2), definitions of *electroconvulsive therapy* and *psychiatric surgery* would respectively substitute those two definitions with:

- ***electroconvulsive therapy***—see the *Mental Health Act 2015*, section 49; and
- ***psychiatric surgery***—see the *Mental Health Act 2015*, section 49.

[2.79] Section 46A would replace '*Mental Health (Treatment and Care) Act 1994*' with '*Mental Health Act 2015*' in this section.

[2.80] Dictionary, definition of *mental health facility* would replace '*Mental Health (Treatment and Care) Act 1994*', in this definition, with '*Mental Health Act 2015*'.

Division 2.3.15 Public Advocate Act 2005

[2.81] Section 10(j) would replace '*Mental Health (Treatment and Care) Act 1994*' with '*Mental Health Act 2015*' in this section.

[2.82] Dictionary, definition of *forensic patient*, paragraph (a) would replace 'be suffering from a mental dysfunction or mental illness', in paragraph (a), with 'have a mental disorder or mental illness'.

[2.83] Dictionary, definition of *forensic patient*, paragraph (d) would substitute paragraph (d) in this definition with '(d) found guilty of a criminal offence and is, or while serving a sentence of imprisonment has become, a person with a mental disorder or mental illness'.

[2.84] Dictionary, definitions of *mental disorder* and *mental illness* would replace, in those two Dictionary definitions, '*Mental Health (Treatment and Care) Act 1994*' with '*Mental Health Act 2015*'.

Division 2.3.16 Victims of Crime Act 1994

[2.85] Section 11 (ba) would replace '*Mental Health (Treatment and Care) Act 1994*' with '*Mental Health Act 2015*' in section 11(ba).

Dictionary would be provided by clause 3 and define the following:

- ***ACAT mental health provision***.
- ***advance agreement***.
- ***advance consent direction***.
- ***affected person***.
- ***affected person register***.
- ***approved community care facility***.
- ***approved mental health facility***.
- ***assessment***.
- ***assessment order***.
- ***authorised ambulance paramedic***.
- ***authorised officer***.
- ***care and protection order***.
- ***care coordinator***.
- ***carer***.
- ***close relative or close friend***.
- ***community-based sentence***.
- ***community care facility.***
- ***community care order***.
- ***community care service***.
- ***coordinating director-general***.
- ***correctional patient***.
- ***corrections director-general.***
- ***corrections order.***
- ***corresponding law***.
- ***Crimes Act***.
- ***CYP director-general***.
- ***decision-making capacity***.
- ***detainee***.

- ***director-general***, for Part 7.2 (Affected people).
- ***electroconvulsive therapy***.
- ***electroconvulsive therapy order***.
- ***eligible person***, for Part 13.2 (Licences).
- ***emergency assessment order***.
- ***emergency electroconvulsive therapy order***.
- ***entitled person***.
- ***forensic community care order***.
- ***forensic mental health order***.
- ***forensic patient***, for Part 7.2 (Affected people).
- ***forensic psychiatric treatment order***
- ***general president*** of ACAT.
- ***health attorney***.
- ***information sharing entity***, for Part 12.5 (Sharing information—government agencies).
- ***information sharing protocol***, for Part 12.5.
- ***information statement.***
- ***inspector***, for Chapter 13 (Private psychiatric facilities).
- ***interim care and protection order***.
- ***interim therapeutic protection order***.
- ***interstate authorised person***, for Chapter 15 (Interstate application of mental health laws).
- ***interstate community care facility***, for Chapter 15.
- ***interstate community care service***, for Chapter 15.
- ***interstate involuntary treatment order***, for Chapter 15.
- ***interstate mental health facility***, for Chapter 15.
- ***interstate mental health service***, for Chapter 15.
- ***interstate patient***, for Chapter 15.
- ***licence***, for Chapter 13—see section 123 (Definitions—ch 13).
- ***licensed premises***, for Chapter 13.
- ***licensee***, for Chapter 13.
- ***mental disorder***.
- ***mental health facility***.
- ***mental health officer***.
- ***mental health order***.
- ***mental health professional***.
- ***mental health service***, for Chapter 15.
- ***mental illness***.
- ***mental impairment***.
- ***nominated person***.
- ***non-presidential member*** of ACAT.
- ***official visitor***.
- ***presidential member*** of ACAT.
- ***principal official visitor***.
- ***private psychiatric facility***, for Chapter 13.
- ***psychiatric surgery***.
- ***psychiatric treatment order***.
- ***psychiatrist***.

- ***publish***, for Part 7.2 (Affected people).
- ***registered affected person***, in relation to a forensic patient.
- ***referring officer***.
- ***psychiatric facility.***
- ***relative***.
- ***relevant information***, for Part 12.5 (Sharing information—government agencies).
- ***relevant official*** for a mental health order, for Chapter 5 (Mental health orders) and for a forensic mental health order, for Part 7.1 (Forensic mental health orders).
- ***relevant person*** for a mental health order application, for Chapter 5 and for a forensic mental health order application, for Part 7.1.
- ***representative***, of a treating team, for Part 3.3 (Advance agreements and advance consent directions).
- ***responsible person***, for Part 3.1 (Rights in relation to information and communication).
- ***restriction order***.
- ***reviewable decision***, for Chapter 16 (Notification and review of decisions).
- ***subject person***, for Chapter 11 (ACAT procedural matters).
- ***transfer direction***—see section 48ZZJ(3) (Transfer to mental health facility).
- ***treating team***, for a person with a mental disorder or mental illness, for Part 3.3.
- ***treatment, care or support***, for a mental disorder or mental illness.
- ***victims of crime commissioner***.
- ***visitable place***.
- ***young detainee***.
- ***young offender***.
- ***young person***.