Review of the ACT
Mental Health (Treatment and Care) Act 1994

Response to First Exposure Draft
Introduction

Thank you for the opportunity for the ACT Human Rights Commission to provide feedback on the draft Mental Health (Treatment and Care) Act. We support the principles of the Review, in particular the focus on the legislation being changed to:

- meet the requirements of the ACT Human Rights Act 2004;
- reflect changes nationally and internationally regarding increased focus being placed on decision making capacity, which is consistent with human rights, particularly the UN Convention on the Rights of People with Disabilities;
- adopt advance agreements, which are also consistent with human rights and better recognition of capacity as a significant element;
- implement a model in which treatment and care is to be provided in the least restrictive environment and via least restrictive methods.

Thank you also for adopting our recommendation that an Exposure Draft of the new Mental Health (Treatment and Care) Act be developed to assist the community to provide feedback.

Human rights

There are many human rights engaged by legislation of this type. In the time available, the Commission has only been able to consider in detail what appear to us to be the most substantive and serious limitations on rights. Our submission should not necessarily be read as an endorsement of all the potential human rights limitations contained in the Bill. However, overall, we support the intention and substance of the draft Bill.

As we noted in our submission to the Option Papers, there are many human rights implications arising from the current system, and the reforms proposed. In assessing these, the Commission is mindful that s28 of the Human Rights Act 2004 (‘the HR Act’) provides that rights under the Act may only be limited by Territory laws where such limitations are reasonable and can be demonstrably justified in a free and democratic society. Section 28(2) provides criteria for making this assessment of proportionality. In deciding whether a limitation is reasonable, all relevant factors must be considered including:

(a) the nature of the right affected;
(b) the importance of the purpose of the limitation;
(c) the nature and extent of the limitation;
(d) the relationship between the limitation and its purpose;
(e) any less restrictive means reasonably available to achieve the purpose the limitation seeks to achieve.

The Commission continues to advocate that the legislation should at least reflect the UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care. As a Resolution of the UN General Assembly, these satisfy the definition of ‘international law’ under s31 of the HR Act and so can be used to interpret...

1 GA Resolution 46/119 of 17 December 1991.
rights under the HR Act. We note that the UN Principles are baselines rather than a ceiling for human rights compliance. For example, in the ‘Application of Rights Analysis Instrument to Australian Mental Health Legislation’ (2000)\(^2\) for the Australian Health Ministers’ Advisory Council (AHMAC) it was noted that some Australian jurisdictions were:

’...concerned that voluntary patients in facilities also approved to detain involuntary patients, could be subject to the overt or covert threat of being made an involuntary patient. The UN Principles do not adequately address this issue, except to provide for an active right of discharge, and preference for voluntary admission.’

The Commission also remains mindful of the obligations under the recent Convention on the Rights of Persons with Disabilities (‘CRPD’). Australia’s likely ratification to the Optional Protocol Against Torture may also have a bearing on how institutions governed by these provisions are inspected and monitored in future.

Consistent with these obligations, and as recommended by the Australian Human Rights Commission (then the Human Rights and Equal Opportunity Commission) in its 1993 ‘National Inquiry into the Human Rights of People with Mental Illness’ (‘the Burdekin Report’), legislative criteria for involuntary admission should be specific and should include the requirement that there is no less restrictive form of appropriate treatment available.\(^3\)

**Key amendments**

**1. Reasonable and necessary force**

Proposed subsections 35(2A) and (2B) (clause 27) would grant new powers and place new obligations on the Chief Psychiatrist, in relation to individuals on involuntary mental health orders. We welcome the restriction in proposed s35(2A) that a person in involuntary seclusion must be examined in each four hour period.

However, we are concerned about s35(2B), which gives the Chief Psychiatrist the ability to use, or authorise someone else to use, the force and assistance necessary and reasonable to give medication to a person on a psychiatric treatment order. We recognise that in using this power, and the other existing powers in the current s35, the Chief Psychiatrist must have regard to the new objects and principles in the Act. We also note that clause 29 would add the involuntary giving of medication to the matters in s35(4), of which the Chief Psychiatrist must keep a record and advise the PA and ACAT.

Nonetheless, while these sections echo existing provisions regarding community care orders, we would suggest this might be amended (and other similar provisions throughout the Bill concerning force) to refer to using the ‘minimum’ force reasonable and necessary. We suggest this be used consistently through the Bill, so that proposed sections 48ZG, 48ZM and 48ZT regarding forensic orders, also refer to *minimum* force.

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\(^2\) Prepared by Dr Helen Watchirs

2. **Capacity cannot be overridden by an involuntary treatment order, unless there is an overriding risk to their safety or the safety of others**

We welcome that the proposed amendments will result in capacity being a far greater consideration in involuntary treatment than is currently the case. We agree with the discussion on page 3 of the Explanatory Statement that this is consistent with national and international law, most particularly the United Nations Convention on the Rights of Persons with Disabilities.

The Objects of the Act will be amended to explicitly recognise the promotion of capacity, and there are new principles with a focus on informed consent. There is also a new s9 detailing principles of decision-making capacity. We note that these are drawn from the Code of Practice for the UK *Mental Capacity Act 2005*, legislation that we cited favourably in our previous written submission to the Review. We particularly welcome the presumption of capacity contained in s9 and submit that such a presumption is consistent with s10(2) of the HR Act (consent to medical treatment) and necessary to ensure any capacity-based scheme will operate in a manner consistent with human rights.

The most substantive change regarding capacity is in proposed sections 28 and 36 (clauses 22 and 30) which now emphasise that an involuntary psychiatric treatment order or community care order can only be made if:

- the person lacks capacity; or
- if they have capacity, the ACAT is satisfied that the harm or likelihood of harm to self or others, or the person suffering serious mental or physical deterioration, outweighs the right to refuse treatment.

We welcome also that treatment must still be provided in the least restrictive way and the requirement in proposed sub-sections 29(3) and 36A(3) (clauses 24 and 31) that a record be kept of the assessment of decision-making capacity.

As we stated in our original submission, Article 12 of CRPD recognises the full legal capacity of all people with disability. It has been suggested by some commentators that the effect of Article 12 is to prevent involuntary psychiatric treatment in any situation. However, the growing consensus in Australia appears to be that Article 12(4) does provide the basis for lawful involuntary treatment and substitute decision making.

We note that risk will nonetheless remain a relevant factor in determining involuntary treatment. This is consistent with our original submission. We submitted that a capacity test alone, as suggested by some commentators, may not be consistent with the United Nations Principles. While the Principles are not binding, given the uncertainty over the CRPD impact on involuntary treatment, they remain the clearest statement in international law on how involuntary treatment should be applied to those with mental illness.
We further note the Explanatory Statement’s reference to no jurisdiction yet moving to a ‘pure’ capacity based legislation. In light of the authorities cited in our original submission, we support the proposed approach. We welcome the move to review the involuntary orders provisions in three years time. By then, there will likely be greater international and national literature, and potentially legislation and jurisprudence, on the question of whether capacity alone should be the sole test for involuntary treatment, including in human rights terms. In the meantime, we believe the proposed changes make the MH Act more compliant with the HR Act.

On a related question, the Commission is aware of work being undertaken to trial supported decision making in the ACT. This is consistent with the growing acceptance of viewing capacity as occurring on a spectrum determined by circumstance, rather than a definitive ‘yes or no’ question.

We support such a trial, but are also mindful of the specific legislative amendments suggested by the recent Victorian Law Reform Commission’s review of guardianship law. We suggest that the majority of legislative changes needed to assist the adoption of supported decision making, and other alternatives to substitute decision making, would likely be in the area of the guardianship law. Nonetheless, one of the issues for this review of mental health legislation has been the intersection of the two bodies of law. We request that the ACT Government commit to a comprehensive review of the Guardianship Act at the conclusion of the MH Act review, and be willing to consider any amendments that may be required to the new Mental Health Act following a review of guardianship law.

3. **Those who are willing to give consent, but may not have the capacity to do so, must have their consent provided by a third party**

We note that the proposed amendments will give guardians and attorneys the power to consent to mental health treatment on behalf of others. The Commission recognises this amendment seeks to address a complex issue that we identified in our original submission. That is, how best to protect individuals who may appear to be consenting to mental health treatment, but lack the requisite capacity. We noted in our submission concerns in this jurisdiction and others about ‘restrictive practices’ being applied to individuals without independent oversight, including in mental health facilities, disability homes, aged care facilities, respite facilities, hospitals and private homes which may not have a sound legal basis. Such action by an ACT Public Authority would be contrary to obligations under s40B of the HR Act in respect of the right to liberty and security of the person under (s18). Similar issues were considered by the European Court of Human Rights in the case of *HL v United Kingdom*.

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5 45508/99 (2004) ECHR 471
We accept that these amendments are an appropriate first response to this issue, and include a number of safeguards, including a guardian or attorney having to notify ACAT of such consent. However, we recommend further consideration of these issues.

Firstly, a guardian or attorney may not be sufficiently aware of the law to know when and how they should notify ACAT of such decisions. As the treating team has presumably formed the view that a person is accepting treatment, but lacks capacity, and has therefore discussed consent with a guardian or attorney, we recommend that proposed s70A of the Guardianship and Management of Property Act 1991, be amended so that the treating team be responsible for notifying ACAT.

We note previous discussions of the Review Advisory Committee regarding other protections that could be considered for this cohort. We remain concerned about those individuals whose capacity may not be questioned adequately, or whose guardians may potentially consent to inappropriate treatment without notifying ACAT or any other oversight agency. We continue to advocate that further steps be considered to deal with these situations, including:

- a full review of guardianship law, to consider amongst other things, options other than substitute decision-making;
- consideration of schemes operating in other Australian jurisdictions, such as the Office of the Senior Practitioner in Victoria, which mandates the submission of treatment plans to an independent agency for review.

In addition, and because of these concerns, we would also question if these amendments should also be subject to a future review to test if they are addressing these issues in an appropriate manner.

4. Restrictions on ECT and related matters

We note that the proposed amendments will result in those aged under 12-years-old not receiving ECT, and enhanced protections for those over 12-years and under 18-years receiving such treatment. We also welcome the addition of capacity as a consideration for the making of an order for ECT.

5. Maximum period of emergency detention

We note the exposure draft includes extensions to the periods of involuntary detention to provide for assessment and emergency treatment. Staff from the Commission considered these provisions in the working group for the review and we are aware of the complex human rights questions that these provisions raise, as reflected in the draft Explanatory Statement. Initially, the Commission was concerned about any increase to the period of emergency detention. The proposed changes in clauses 56 and 57 would extend the period for detention for assessment from 7 days to 11 days. However, we recognise the arguments that such a change may result in less long-term psychiatric treatment orders and community
care orders being granted because of the increased time for assessment and treatment provided. Therefore the Commission tentatively supports these changes, but would only continue to do so if they were accompanied by the protections in clause 57, being:

- the right to seek a review of the additional 11 day order;
- a review of their use 18 months after commencement;
- a report from the Minister on that review two years after commencement; and
- that unless otherwise amended, they expire in three years time.

We are particularly mindful that such detention would remain the shortest amongst Australian jurisdictions.

6. Advance Agreements

The Commission advocated for the legal recognition of Advance Agreements (AAs) in our original submission. We noted the comments of Professor Rees regarding the requirements for the appropriate operation of Advanced Agreements,

‘.... the test for capacity at the time an ‘advance directive’ is made, the identity of the person or persons who must attest to the person’s capacity at the time an advance directive is made, the means by which an ‘advance directive’ is drawn to the attention of relevant clinicians, the scope of an advance direction, the circumstances (if any) in which a person’s clearly expressed wishes in an ‘advance directive’ may be overridden, and the identity of the person (or body) who (or which) may be invested with the power to override an ‘advance directive’’.6

We argued that clinical decision makers should not have unfettered power to override the advance directives of consumers. Such power was criticised by the UK Joint Parliamentary Human Rights Committee in relation to the 2002 draft UK Mental Health Bill as inconsistent with the European Convention on Human Rights (ECHR).7

It appears the proposed amendments address both the concerns of the UK Parliamentary Committee and Professor Rees, in particular by requiring a treating team to apply to ACAT if they wish to override the consumer’s wishes in an AA without their consent.

However, under proposed sections 53I and 53L (clause 72) an AA may be overridden by a guardian or power of attorney. Currently, guardians and attorneys do not have the power to consent to mental health treatment. While the Exposure Draft Bill includes other amendments that would change the role of guardians regarding mental health treatment, these amendments only allow guardians to consent to mental health treatment where the person appears to be consenting but lacks capacity. In contrast, proposed sections 53I and 53L appear inconsistent with the principle that a third party not be able to consent to

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involuntary mental health treatment on behalf of an individual. This may also limit the right to consent to medical treatment in s10(2) of the HR Act. These amendments would result in a person’s express wishes being overridden by the guardian or power of attorney. No explanation is given for this position in the Explanatory Statement.

We assume the intent of these sections is to only allow such overriding consent when an order of the ACAT authorises it, as these proposed sections refer to the AA being inconsistent with ‘a provision of the appointment’. Nonetheless, these provisions concern us, as they potentially allow guardians and attorneys wide power to override AAs in situations where the appointment provision is vague, unclear or broad. Our preference would be that no one can consent to an AA being overridden for treatment, without an explicit order of the ACAT.

The Draft Explanatory Statement also notes: In the process of developing the legal framework for AAs, a number of consumer representatives expressed the wish that an AA would remain legally binding on them if they attempted to withdraw it when unwell and lacking capacity. However, the balance of opinion was that the person should always have the right to withdraw consent, whether they have capacity or not. The Commission does not recall that such a balance of opinion was achieved, and believed that the view of the consumer representatives, and of the Health Services Commissioner, had been accepted. The purpose of developing an AA is precisely because consumers wish them to apply when they do not have capacity. The proposal that a person could withdraw consent when they lack capacity is contrary to the purpose of developing an AA scheme. The Commission recommends that this provision be amended to ensure that an AA continues to apply when a consumer lacks capacity to withdraw or amend it.

7. Forensic mental health orders

We note that the proposed amendments will result in a new suite of forensic mental health provisions and orders.

In our original written submission, we noted that Dawson and Szmukler offered an approach for a forensic system where the non-forensic system uses capacity as the model of care involving:

- Any prisoner or forensic patient with capacity who consents to treatment may be treated voluntarily in an appropriate facility, during which sentence would continue to run.
- When forensic patients lack the capacity to make treatment decisions, their treatment without consent would be justified on the same basis as other non-forensic incapacitated patients.
- When prisoners lack the capacity to consent to treatment, their transfer to hospital and treatment without consent would be authorised [presumably by an independent adjudicator such as a court or tribunal]. If they regain capacity, treatment could continue only with their consent, with return to prison if they refused.
- In the case of those found not guilty by reason of insanity or unfit to stand trial, who cannot be sent to prison, their treatment without consent might be lawful even if
they retained capacity. This is because they have been shown, on reliable evidence, to have committed the acts or omissions necessary to constitute a serious offence; they are suffering from a serious mental disorder that contributed significantly to their conduct; and an effective treatment can be offered that could reasonably be expected to reduce the risk of recurrence. This could be the limited exception to pure incapacity principles, necessary to reduce the risk of harm to others.

- Upon a person’s conviction for a serious criminal offence, an appropriate prison sentence would be imposed. Offenders who were found to lack capacity to consent to treatment at that time could still be directed to hospital for treatment, and during their time in hospital, their prison sentence would continue to run. If they regained capacity and refused treatment, however, they would be transferred to prison to continue their sentence. At the end of their sentence, if capacity was not regained, their involuntary treatment could continue as a civil patient.

Alternatively, a criminal court imposing a hospital order for treatment following a person’s conviction could set a limiting term, proportionate to the seriousness of the offence, during which the involuntary treatment would be lawful despite that person having capacity, on the same conditions as those stated above for those found not guilty by reason of insanity. 8

It appears new Chapters 6 and 7 of the amendment Bill reflect these principles. We welcome the specific discussion of the HR Act at the beginning of this section of the draft Explanatory Statement, and that the new objects and principles of the Act will apply to the making of decisions regarding forensic orders. We also particularly welcome that these new forensic orders will only apply to those in the criminal justice system already, as defined in new sections 48J and 48Q. The Commission has remained vigilant throughout this process that mental health laws not be used to criminalise otherwise legal behaviour, or place those with mental illness or dysfunction inappropriately into the criminal justice system. The Commission continues to advocate that only those charged or convicted of a criminal offence should be subject to the forensic orders contemplated in Chapters 6 and 7.

There is no doubt that these orders engage a number of rights and will do so in a significant way for a number of mental health consumers. In the time available, overall, the provisions appear to do so in a reasonable and proportionate way. Critical to this question is that under proposed s48Z (clause 70) the ACAT must be satisfied that the involuntary treatment will have a therapeutic benefit. We submit that this element is crucial to the proposed scheme ensuring that any order made by the Tribunal does not unreasonably limit rights.

However, we wish to clarify one issue. The draft Explanatory Statement states:

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

We support this approach. However, it appears that proposed s48ZZC would allow a detainee to be transferred without their consent to an approved mental health facility, with a detainee having to seek a subsequent review from ACAT under s48ZZH. We suggest that s48ZZC be amended to require that the Director-General only transfer a detainee with their consent. This would be consistent with Principle 20 of the United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, which states detainees may only be transferred to a mental health facility when:

‘Domestic law may authorize a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons be admitted to a mental health facility.’

On the basis of equivalence, the only exception we would see to this approach is situations where a detainee must be subject to an emergency detention and assessment order, in which case the usual safeguards applying to civil patients should also apply, including the maximum timeframes of 3 and 11 days under the new proposed regime.

In relation to affected persons, we are not necessarily opposed to affected persons being given the opportunity to put their views before the ACAT. However, we submit that the relevant question on which they can provide specific evidence relates to whether, if the forensic patient were not detained, there would be risk of serious harm to others (proposed s48Z(n) and (o), 48ZB(c) and 48ZH(c)). We suggest that s48Z(f) be amended to reflect this.

As noted in the draft Explanatory Statement, there are clear limitations on the right to privacy of forensic mental health consumers regarding the information disclosed by the Director-General (responsible for the ACAT) to an affected person about that person. We recognise that the Bill is seeking to strike a balance between the legitimate needs of affected people, and the interests of those subject to a forensic mental health order. Nonetheless, we would suggest that the appropriateness of this balance can likely only be assessed once the provisions are operational, particularly regarding their impact on offenders under the age of 18 years, who are particularly vulnerable.

We note that certain appropriate bodies are exempted from communication bans in proposed new s48ZO and question whether this section might also note the existing jurisdiction of oversight bodies where legislation provides a right to obtain information. For example, this would include Commissioners of the Human Rights Commission when considering a complaint from a relevant person.

In relation to information sharing, the Commission recognises the challenges that a lack of shared information has caused in corrections environments. As we noted in our original submission, the sharing of an individual’s health information would limit the right to privacy in the HR Act (s12). Nonetheless, such limitation may be proportionate and reasonable in circumstances where it is intended to assist in the care of the person. However, such sharing of information would have to be limited in its coverage and in clearly defined circumstances in order to be proportionate. In particular, there are safeguards and procedures for the transfer of information governed in legislation, for example the ACT Health Records (Privacy
and Access Act) 1997, under which the Health Services Commissioner may handle complaints.

Further, in our 2011 Review of the Youth Justice System, which encompassed a Human Rights Audit of the Bimberi Youth Detention Centre, we recommended:

‘Recommendation 13.20: The Community Services Directorate and the Health Directorate jointly develop a protocol to resolve issues concerning the sharing of information between their staff, particularly regarding concerns about a young person’s mental health at Bimberi.’

In making such a recommendation, we noted the need to strike the right balance between an individual’s right to privacy and the need for awareness amongst staff in a closed environment of risks of self-harm.

We note that proposed powers of presidential members of ACAT to issue arrest warrants has been subject to adverse comments by the Legislative Assembly Scrutiny of Bill’s Committee. In Scrutiny Report No 34 of the 6th Assembly, the Committee was concerned by a proposed amendment to the Health Professionals Act 2004 to provide a Tribunal presidential member with the power to issue a warrant for the arrest and detention of a person. In that case, the Tribunal was particularly concerned that the power related to those ordered to appear before the Tribunal as a witness. The Committee was also worried about the lack of time limit of such detention and the absence of an independent review of the exercise of the power to detain.

The Committee elaborated on these concerns in Scrutiny Report No 55 of 6th Assembly concerning the ACT Civil and Administrative Bill 2008. In both reports, the Committee questioned whether the involuntary detention of a citizen is an exclusively judicial function, however noted High Court authority that detention orders implemented by the executive may be valid when for ‘protective’ purpose, as opposed to a punitive one. That is likely to be the case in relation to the proposed provisions.

The Committee has been keen to see Explanatory Statements detail the justification for such powers limiting the right to liberty under s18 of the HR Act. While the provisions suggested in the Exposure Draft are different from those criticised previously by the Committee, particularly as they relate only to consumers appearing before the ACAT and are arguably concerned with matters of protective detention, we would recommend that the Explanatory Statement to the Bill address the previous concerns of the Committee in some detail.

Finally, we note that the planned secure forensic mental health unit is not currently contemplated in the Act. Instead, the Act makes provision for the Minister to declare a facility an approved mental health facility. As such, it appears that under the proposed regime a civil patient could be transferred to the forensic unit from another civil approval mental health facility under an existing order. We would seek further consultation prior to the secure unit being operational on what safeguards will be in place regarding the potential transfer of a civil patient to the forensic unit, as this potentially raises significant human rights issues.
Based on these issues, we also submit that these new forensic provisions be subject to a legislative review, as is the case for other provisions of the Bill.

8. Limiting Terms

The Commission welcomes proposed Chapter 7 of the Exposure Draft regarding the treatment of detainees with mental illness or dysfunction, and in particular the clarification about the relevant legislative regimes that apply to detainees receiving voluntary and involuntary treatment. We also note the discussion of relevant human rights in the draft Explanatory Statement, and particular reference to the Standard Minimum Rules for the Treatment of Prisoners.

In our original submission, we noted there are some issues with the current limiting term regime, particularly in relation to the right to liberty of the person (s18). That is, under the current system it appears the Court is sentencing a person as though they have been found guilty of an offence. That is not the case, particularly as the person has been found explicitly not to have the requisite fault element to have committed a criminal act.

Further, they have not had the opportunity to have the sentence discounted in any way, for example by pleading guilty. There is therefore a risk that those with mental illness or dysfunction may spend greater time being potentially subject to detention, than those found guilty of criminal conduct.

Nonetheless, we accepted in that submission the intention of the current scheme is to avoid indefinite or longer detention for those found unfit to plead, as is the case in other jurisdictions. In the period since our submission, we have not found or identified a better system and so accept that the current ‘limiting term’ may provide the minimum limitation on rights possible, bearing in mind the public safety and risk of harm questions that be addressed prior to an order being made.

We have not yet had the opportunity to consider it in detail, but we note the recent decision of the European Court of Human Rights in new Case of James, Wells and Lee v the United Kingdom,\(^9\) that indefinite sentences were a breach of the right to liberty under the European Charter. In one respect, the maximum limiting term scheme contemplated in the draft Bill is consistent with this decision, as the Supreme Court sets a maximum term of detention, with the care to be provided during that maximum period determined by ACAT. However, the Court in that decision also emphasised the need to provide rehabilitation programs to detainees and stated that an individual’s release should not be delayed because of failings of the state to provide the necessary programs or support. In that respect, it might be said that in the context of the draft MH Bill, an individual should not necessarily remain in inpatient treatment for the entire duration of the limiting term in circumstances where they could have been released earlier had appropriate care be provided. Such an analysis is consistent with other decisions of the European Court

\(^9\) Applications nos. 25119/09, 57715/09 and 57877/09, 18 September 2012.
including *Brand*\(^\text{10}\)*, in which a delay of six months before a detainee was transferred to a mental health institution because of his disorder was found to be arbitrary. We are not suggesting a consumer be released into the community prior to the end of their limiting term where they may still represent a risk of harm to self or others. We suggest, however, that a consumer who is unreasonably detained for the full limiting term may have grounds to argue for a later remedy.

9. **Children and young people**

The Commission is mindful of the special protection provided to children under the HR Act (s11) and the obligations contained in international instruments relevant to children and young people, most particularly the United Nations Convention on the Rights of the Child. A number of provisions would result in children being involuntarily treated or detained, although at times greater safeguards are included in the legislation for how such powers are exercised in relation to children and young people. We submit that a section of the Explanatory Statement detail specifically with the limitations on the rights of children and young people of the proposed amendments, and how such limitations are reasonable.

10. **Further guidance material**

Given the complexity of the new scheme, we submit that plain English guidance material be developed to assist carers and consumers navigate the new system.

\(^{10}\) *Brand v. the Netherlands*, no. 49902/99, § 62, 11 May 2004