

[By email: [mhactreview@act.gov.au](mailto:mhactreview@act.gov.au)]

## **Submission to the Review of Mental Health Orders and Forensic Mental Health Orders under the Mental Health Act 2015**

### **About the ACT Human Rights Commission**

The ACT Human Rights Commission is an independent agency established by the *Human Rights Commission Act 2005* (ACT) ('the HR Commission Act'). Its main object is to promote the human rights and welfare of people in the ACT. The HR Commission Act became effective on 1 November 2006 and the Commission commenced operation on that date.

The HR Commission includes:

- The President and Human Rights Commissioner;
- The Public Advocate;
- The Children and Young People Commissioner;
- The Disability and Community Services Commissioner;
- The Discrimination Commissioner;
- The Health Services Commissioner; and
- The Victims of Crime Commissioner.

Commissioners fulfil various oversight functions in relation to mental health orders and forensic mental health orders under the *Mental Health Act 2015* ('the MH Act'). Our submission is informed by our experiences and observations of how the mental health system is operating in relation to the new MH Act.

The President and Human Rights Commissioner's role includes advising government on the impact of laws and government services on human rights. The Human Rights Commissioner and her staff participated in the significant review that led to the passage of the new MH Act.

The Health Services Commissioner's role includes dealing with complaints about health services provided in the ACT, including mental health services for people who are subject to treatment orders.

The Victims of Crime Commissioner's role includes overseeing the functions of Victim Support ACT, advising the Attorney-General on matters relating to victims of crime, advocating on a systemic and individual basis for the interests of victims of crime, facilitating cooperation between agencies involved in the administration of justice, and monitoring and promoting compliance with the governing principles for the treatment of victims of crime.

The role of the Public Advocate (PA) is one of oversight and monitoring of compliance with the legislative requirements in the MH Act. Part of that function is the review of all mental health notifications to the PA for involuntary detention of mental health consumers. From this paperwork, we can identify system breaches of compliance with the MH Act as well as consumers who may benefit from PA advocacy support generally and at their ACT Civil and Administrative Tribunal (ACAT) hearing. The identification of systemic issues is also foremost in the PA's oversight role. In this setting the PA advocates for least restrictive practice to be exercised by the ACAT when considering the making of a mental health order. This is in keeping with the principles of the MH Act.

At this time, the executive officer functions for the Office of the ACT Care Coordinator is undertaken by the Public Advocate. The capacity and appropriateness of the PA continuing to perform this function has been subject to recent review.

We have organised our submission into the questions posed in the discussion paper.

### **Observations on the implementation of mental health orders and suggested changes**

We note that any provision of treatment, care and support to a person under a mental health order, whether that is a psychiatric treatment order (PTO) or community care order (CCO), will generally include that treatment, care and support being provided involuntarily and potentially against the express wishes of the person. Therefore, several human rights are limited by the provisions of such treatment, including equality (s 8), consent to medical treatment (s 10(2)), and potentially liberty and security of the person (s 17) and humane treatment when deprived of liberty (s 18).

In assessing these, the Commission is mindful that section 28 of the *Human Rights Act 2004* ('the HR Act') provides that rights under the HR Act may only be limited by Territory laws where those limitations are reasonable and can be demonstrably justified in a free and democratic society. Section 28(2) provides criteria for assessing whether such limitations are proportionate and therefore 'reasonable'. 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.

#### *Capacity versus Risk*

One of the key changes in the criteria for making Mental Health Orders (MHOs) was to place greater emphasis on a person's capacity and wishes. The MH Act, as passed in 2015, did not create a 'pure' capacity model for mental health orders on the basis that such a model had not been tested in other jurisdictions. Such a model would involve a person only receiving mental health care when they choose to accept such care, including providing appropriate supports to reach capacity to make such a decision.

In our previous submissions to the review of the *Mental Health (Treatment and Care) Act 1994* ('MH Act 1994'), the Commission advocated that the legislation should reflect the requirements of the Convention on the Rights of Persons with Disabilities ('CRPD') and the UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care. These satisfy the definition of 'international law' under section 31 of the HR Act and so can be used to interpret rights under the HR Act. In particular, article 12 of the CRPD recognises the full legal capacity of all people with disability. In our previous submissions to the review of the MH Act 1994, we noted some legal commentary that the effect of article 12 was to prevent involuntary psychiatric treatment in any situation. However, we suggested there was arguable consensus in Australia that article 12(4) does provide the basis for lawful involuntary treatment, provided it is only used as a last resort. This consensus informed Australia (among other countries) in choosing to express reservations regarding article 12, declaring that it does provide for some substituted decision making.

Since then, there has been growing academic discussion that article 12 requires that legislation no longer be based on 'the status of being diagnosed with a mental disorder coupled with the risk of harm to self or to

others', but rather 'impaired decision-making capacity'.<sup>1</sup> For example, George Szmukler, of the Institute of Psychiatry, Psychology and Neuroscience at King's College London, advocates for a single capacity based law that is:

*'...squarely based on decision-making capability and that such a generic law would be consistent with the Article 12 requirement that individuals with disabilities shall "enjoy legal capacity on an equal basis with others". Any person, with or without a disability, may develop an impairment of decision-making capability following an event causing a disturbance of mental functioning. There is certainly work to be done in further developing its assessment as well as the meaning of "best interests" for those with impaired decision-making.'*<sup>2</sup>

In 2017, the UN Special Rapporteur on the right to health called for a 'radical reduction and eventual elimination' of coercion and force in mental health treatment.<sup>3</sup> Similarly, the UN High Commissioner for Human Rights has called for these types of regimes, known as substitute decision making, to be replaced by supported decision making.<sup>4</sup>

Such a view is not without controversy. Martin Zinkler, of the Teaching Hospital of Ulm University in Germany, has observed that 'within psychiatry the uptake of the convention with supported decision making was rather hesitant and perceived as challenging'.<sup>5</sup> Julian Eaton, Co-Director of the Centre for Global Mental Health, similarly notes that there is 'divergence on the fundamental issue of treatment without consent in certain circumstances' and that despite ratifying the CRPD, 'almost all countries, including the UK, are in contravention'.<sup>6</sup>

Some academic commentators have advocated for a more hybrid model such as that proposed by Bach and Kerzner in Canada, which seeks to create a minimum threshold for exercising legal capacity based on the assessment of another person with personal knowledge of that individual.<sup>7</sup> In contrast, Scholten and Gather have identified 'six adverse consequences' of adopting the pure article 12 approach for persons with mental disabilities, including that there is a greater risk of 'undue' influence from those around a person and that responsibility for treatment decisions can be more complicated, particularly where a person who lacks decision making capacity bears all the responsibility for their treatment.<sup>8</sup>

This submission does not seek to comprehensively explore all academic literature regarding criteria for involuntary mental health treatment, but this discussion does illustrate that, as a human rights jurisdiction, the ACT should continue to consider reform to the criteria for the making of involuntary orders under the MH Act. We note that the introduction of advanced agreements, nominated persons and advanced care

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<sup>1</sup> G Szmukler, 'UN CRPD: Equal recognition before the law' (2015) 2(11) *Lancet Psychiatry* 29.

<sup>2</sup> Ibid.

<sup>3</sup> Dainas Pūras, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, UN Doc A/HRC/35/21 (28 March 2017).

<sup>4</sup> Human Rights Council, thirty-fourth session, *Mental health and human rights - Report of the United Nations High Commissioner for Human Rights*, page 9. (27 February to 24 March 2017)

<sup>5</sup> Martin Zinkler, 'Supported Decision Making in the Prevention of Compulsory Interventions in Mental Health Care' (2019) 10 *Frontiers in Psychiatry* 137.

<sup>6</sup> Julian Eaton, 'Human rights-based approaches to mental health legislation and global mental health' (2019) 16(2) *BJPsych International* 37.

<sup>7</sup> Michael Bach and Lana Kerzner, 'A new paradigm for protecting autonomy and the right to legal capacity: advancing substantive equality for persons with disabilities through law, policy and practice' (2010), *Law Commission of Ontario*, <https://www.lco-cdo.org/wp-content/uploads/2010/11/disabilities-commissioned-paper-bach-kerzner.pdf>

<sup>8</sup> Matthé Scholten and Jakov Gather, 'Adverse consequences of article 12 of the UN Convention on the Rights of Persons with Disabilities for persons with mental disabilities and an alternative way forward' (2017) 44(4) *Journal of Medical Ethics*, 226-233, <https://jme.bmj.com/content/medethics/44/4/226.full.pdf>

agreements, coupled with the increased emphasis on capacity in the MH Act, are consistent with the intention of the CRPD to provide greater autonomy for consumers.

Nonetheless, in our experience, the application of the MH Act by the ACAT still predominantly involves an overly risk-averse approach. Orders tend to focus on risk, often historical rather than current, despite the consumer having decision making capacity and being in compliance with treatment care and support. This is neither least restrictive nor mindful of the dignity of risk principle. Orders may be necessary where present risks are unacceptably high to either self or others, but there are many instances in which we have observed the making of orders based on historical risk from many years prior, which denies the consumer the opportunity for autonomy.

#### **CASE STUDY A**

AB was a homeless mental health consumer who was placed on a PTO by the tribunal due to an historical documentation that suggested he may have been a risk to others, some years ago. The ACAT noted this as well as forming the opinion that his homeless status placed him at a high risk of deterioration and non-compliance, despite his ongoing willingness to engage in treatment, care and support. Also worth noting, were his claims of being a philosophy graduate with a major in artificial intelligence and that he was a published author (both true claims) were reported by the treating team as delusions. Despite full engagement with his community mental health team and full compliance with all treatment, care and support, he was placed on a six month PTO based solely on historical risk. Within days of the order being made AB had the first disability support pension payment and had secured permanent accommodation. The granting of the order was devastating to him and almost derailed his willingness to comply and engage with mental health services. At a later review hearing he showed the tribunal evidence of multiple academic transcripts as well as two books he had authored. The PA's advocacy in this case was instrumental in the PTO being revoked and AB's continuation of full compliance and engagement with mental health services. AB is now enrolled in further full time study and continues to demonstrate stable mental health.

We would advocate that, in keeping with the objects and principles of the MH Act and in consideration of the HR Act, the evidence for placing a mental health consumer on an involuntary order needs to focus more on current risk and compliance, refusal and decision making capacity, rather than historical risk factors. In instances where current risk is not high, consumers should be afforded the dignity of risk to make their own voluntary decisions about care, treatment and support where possible.

#### *Emergency Detention and Emergency Detention and Psychiatric Treatment Orders*

It has recently come to our attention that because a PTO does not authorise detention in a mental health facility, a three-day emergency detention order (ED3) needs to be enacted where a consumer presents to the Emergency Department (ED) and requires detention (provided there is no consultant psychiatrist available to authorise a variation to the consumer's treatment plan). We feel that this is particularly onerous for staff in a busy ED setting where a consumer may present in the early hours of the morning with only a skeleton staff available to respond. We propose an amendment to the treatment plan and that in future a location is specified to provide that authority to detain in an emergency situation.

#### *Community Care Orders*

The PA has observed ongoing confusion among clinicians about the use of and application of CCOs, which apply to those with mental disorder (as opposed to mental illness). This includes powers in relation to CCOs and how restriction orders interact with CCOs. We recommend further training and education on the use of these orders, including on the definition of mental disorder.

Issues have been experienced locating suitably trained and experienced persons to undertake the delegations of the Care Coordinator, particularly for people with eating disorders on a CCO or in matters where serious risks present. Previously, Disability ACT often agreed to take on delegations, where this was appropriate. With the changed disability service landscape and the NDIS, this issue has become more apparent. Clear policies and procedures need to be developed in regard to the use of CCOs, the development of community care plans, suitable appointment of delegates and the reporting requirements for these orders.

### **Observations on the implementation of forensic mental health orders and suggested changes**

In addition to the human rights limited by PTOs and community care orders (CCOs), forensic versions of these orders under the MH Act involve a further limitation on rights, particularly as a person's decision making capacity, consent and wishes are not given formal consideration under the explicit criteria for these orders. Instead, the criteria for such forensic orders requires ACAT to consider:

1. that the person with a mental illness or disorder is involved in the criminal justice system;<sup>9</sup>
2. that because of the mental illness or disorder, there has been or is likely to be serious endangerment to public safety;<sup>10</sup> and
3. ACAT must be satisfied, in the circumstances, that a MHO should not be made.<sup>11</sup>

We note the overarching principles included in the MH Act do still contemplate the person's capacity and wishes.

During the previous review of the MH Act 1994, the Commission submitted that forensic orders should not be used to criminalise otherwise legal behaviour, or inappropriately refer those with mental illness or dysfunction into the criminal justice system. On balance, we offered cautious support for these new orders on the basis the ACAT must be satisfied that the involuntary treatment will have a therapeutic benefit. We submitted that this element was crucial to the proposed scheme ensuring that any order made by the Tribunal does not unreasonably limit rights.

Similarly, the Commission noted that the sharing of information with affected persons, including victims, in relation to such orders further engaged the individual's right to privacy. There is acknowledgment however in Australia and internationally that victims of crime also have rights, including rights to information about and participation in the administration of justice that co-exist with the rights of the accused. Many of these rights exist already in the ACT's criminal procedures, for example the right for victims to participate in sentencing decisions and the setting of bail conditions. The ACT Victims Charter is also being currently developed to holistically implement and embed victim rights throughout the ACT's entire criminal justice system.

The Affected Persons Register (the Register) was introduced into the MH Act to implement rights for victims of crime where the accused has a mental illness or disorder and a Forensic Mental Health Order (FMHO) is being made or has been made. Specifically, these rights include the right to information and to participate in ACAT proceedings so that victims of crime can manage their safety and wellbeing.

#### *Affected Persons Register*

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<sup>9</sup> ss 94, 101 and 108 *Mental Health Act 2015* (ACT).

<sup>10</sup> S101(2)(c) and 108(2)(c)

<sup>11</sup> S101(2)(e) and 108(2)(f)

An affected person is a person who suffers harm because of an offence committed or alleged to have been committed by a forensic patient.<sup>12</sup> ‘Affected persons’ include primary victims of a crime, family members of the primary victim and others who are financially or psychologically dependent on the primary victim.<sup>13</sup> A forensic patient is defined as a person in relation to whom a FMHO may be made or is in force.<sup>14</sup> The Director-General must enter an affected person’s details on the Register if:

- criminal proceedings are in place;<sup>15</sup>
- the affected person has suffered harm because of the offence;<sup>16</sup>
- the affected person asks or consents to be on the Register;<sup>17</sup>
- the Director-General is satisfied it is necessary for the affected person’s safety and wellbeing;<sup>18</sup> and
- the affected person signs an undertaking not to publish information disclosed.<sup>19</sup>

The Director-General must take reasonable steps to notify affected persons about the Register and also about their rights and responsibilities if they are entered on the Register.<sup>20</sup>

Once an affected person is entered on the Register:

- If a FMHO has been made, the Director-General must share certain information with the affected person (for example, whether the forensic patient absconds or is released from a mental health facility or community care facility or is transferred to or from another jurisdiction), and may also provide any other information considered necessary for the affected person’s safety and wellbeing.<sup>21</sup>
- If a FMHO is being made, ACAT must take into account any statement by the affected person,<sup>22</sup> as well as the views of the Victims of Crime Commissioner in the making of the FMHO.<sup>23</sup>

In situations where an accused person is not guilty because of mental impairment the court can:<sup>24</sup>

- order the accused be detained in custody for immediate review by ACAT; or
- if appropriate, order the accused to submit to the jurisdiction of the ACAT to allow ACAT to make a MHO or a FMHO.

### *The Use of FPTOs and FCCOs*

We recognise that the MH Act seeks to strike a balance between the legitimate needs of affected people, and the interests of those subject to a forensic mental health order. We are therefore concerned that, as far as we are aware, no FPTO or FCCO has been made by the ACAT. Instead, PTOs and CCOs are being used, or at times, conditional release orders under section 180 in isolation, with no corresponding forensic order. This

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<sup>12</sup> S128 *Mental Health Act 2015* (ACT).

<sup>13</sup> S128 *Mental Health Act 2015* (ACT).

<sup>14</sup> S127 *Mental Health Act 2015* (ACT).

<sup>15</sup> ss94, 101 and 108, 127 *Mental Health Act 2015* (ACT).

<sup>16</sup> S128 *Mental Health Act 2015* (ACT).

<sup>17</sup> S132(1)(a) *Mental Health Act 2015* (ACT).

<sup>18</sup> S132(1)(c) *Mental Health Act 2015* (ACT).

<sup>19</sup> S132(1)(b) *Mental Health Act 2015* (ACT).

<sup>20</sup> S131 *Mental Health Act 2015* (ACT).

<sup>21</sup> S134 *Mental Health Act 2015* (ACT).

<sup>22</sup> S99(1)(f) *Mental Health Act 2015* (ACT).

<sup>23</sup> S99(1)(l) *Mental Health Act 2015* (ACT).

<sup>24</sup> S323(3), s324(2), s328(3), 329(2) *Crimes Act 1900* (ACT).

would seem to frustrate the intent of the new orders, and the specific safeguards that would put in place for such orders, including the legislative test and register of affected persons. Absent any such forensic order, the victim has no right to information or to participate in ACAT proceedings.

In several cases, but not all, the ACAT has proactively invited the Victims of Crime Commissioner to participate in proceedings where an accused has been found not guilty because of mental impairment and referred to the ACAT by the Court. While this opportunity for the Victims of Crime Commissioner to participate is always appreciated, it arises from the ACAT's discretion, rather than a victim's rights as per the original intent of the Register.

#### **CASE STUDY B**

Robert was found not guilty of a serious violent offence against Stella due to mental impairment. The court ordered that Robert be detained in custody for immediate review by ACAT. No FMHO was made.

Stella has not been given leave to participate in hearings or receive information. She does not know where Robert resides and whether or not he is allowed back in the community. She is fearful she may bump into him at any time.

Note: Case study has been de-identified.

#### **CASE STUDY C**

Michael was found not guilty of a serious violent offence against Xavier due to mental impairment. The court ordered that Michael be detained in custody for immediate review by the ACAT. The ACAT then made a conditional release order directing Michael to reside at a mental health facility.

As there was no FMHO, Xavier had no right to appear at the ACAT proceedings or receive information about Michael's whereabouts. However, the ACAT had contacted the Victims of Crime Commissioner and invited her to appear at the initial hearing in Michael's matter. Prior to the hearing, the Commissioner spoke with Xavier and his family to seek their views regarding their safety and the community's safety in the context of a possible Conditional Release Order. The Commissioner appeared at the ACAT hearing and requested, on behalf of Xavier and his family, specific conditions to restrict Michael's whereabouts should he be granted leave from the mental health facility or be released from the mental health facility. Conditions were placed on Michael's CRO to reflect these requests.

The Victims of Crime Commissioner continues to attend regular review hearings for Michael's CRO and to consult with Xavier and his family regarding their ongoing views and safety concerns.

Note: Case study has been de-identified.

## *Recommended Improvements*

FMHOs and FCCOs were tailored to strike a balance between the rights of an accused and an affected person. We are concerned that FMHOs will continue to be rarely or never made in the future because forensic orders will normally not be needed to provide the mentally impaired person with the treatment, care and support required. Such treatment care and support can be provided as either an 'ordinary' MHO or CCO, or pursuant to the CRO. This is a related issue to the one identified above concerning the undue weight placed on risk factors compared to a consumer's decision making capacity and wishes.

Our preferred way forward is that the legislation is better applied in relation to MHO and CCOs, removing the incentive for these to be used in favour of FMHOs and FCCOs. Nonetheless, we are also concerned that conditional release orders may still be used without corresponding forensic orders. Therefore, we suggest that the definition of 'forensic patient' in s127 of the Act be changed to include a person in relation to whom a CRO as well as a FMHO may be made or is in force. This would extend the Director-General's right to share information with affected persons entered on the Register, contained in s134(a) and (b), to circumstances where a CRO is made.

Further, in making a CRO under s180(4) of the Act, the ACAT should be required to take into account any statement by the registered affected person and the views of the Victims of Crime Commissioner. This would mirror the requirements that currently exist in relation to the making of an FMHO under s99(1)(f) and (l). We make this recommendation on the basis that such a minor addition to the process would not prolong a consumer's time in custody while the ACAT consider what orders to make.

We also recommend consideration of the following procedural reforms. When an affected person participates in an ACAT proceeding, consideration should be given to protecting a victim's privacy and confidentiality, albeit remaining mindful of an accused's right to a fair hearing. If a victim is in fear of the forensic patient, disclosing the victim's submissions and personal information to them may only enhance this fear. It is important that affected persons on the register are provided with information about the assistance that the Victims of Crime Commissioner can provide in these circumstances, to ensure, for example, that their submissions are put to ACAT in a way that best protects their privacy and safety.

Where a victim of crime participates in ACAT proceedings in this context, we recommend that there be an ability for the victim to request an explanation from ACAT as to how the victim's views have been taken into account. This is necessary so that victims can understand the outcome of their participation and whether they have been afforded procedural fairness. We note s 60 of the ACAT Act already provides that a party may request a statement of reasons. We suggest that there be clarification and if necessary amendment to this section so that it applies to a victim who has participated in ACAT proceedings for a FMHO, FCCO or CRO. Further, clinicians should also be offered training about the application of forensic orders.

## **Objectives and Principles**

In the course of our oversight functions the PA team speak with mental health consumers on a daily basis. Many consumers familiarise themselves with the MH Act and one message we hear repeatedly concerns the principles in the MH ACT. Most feedback from consumers is that they are misleading and unreasonably raise expectations for involuntary consumers. For example, most involuntary mental health consumers are not lawyers and cannot competently interpret legislation, and when they read that they have the same rights and responsibilities as other members of the community, and the right to refuse or stop treatment, then the interpretation of that may be literal and definitive. This leads to confusion when they are told that they must comply when under orders. We would recommend that the principles of the MH Act also provide clarity in plain English about the role of involuntary orders and how they interact with the principles.



## General Comments

### *ED3 Detention*

The MH Act also adjusted the arrangements for emergency detention and assessment. In regards to the provision in the MH Act for ED3 we would recommend an adjustment to the implementation of the new provisions. Specifically, that the form include a space to record the name of the delegate of the Chief Psychiatrist who upheld the order as evidence of compliance with the legislation. There was recently an instance where the two signatories were both endocrinologists, with no written evidence of the order being upheld by a psychiatrist.

### *ECT*

The Commission also has concerns about the current framework for the provision of electro-convulsive treatment (ECT). We have noted in submissions over several years that this form of mental health treatment in particular raises significant human rights limitations.

The provisions regarding non-emergency ECT in particular do not appear to feature the necessary safeguards. The current MH Act (unlike the previous MH Act 1994) does not require that a second opinion be provided to the ACAT with an application for ECT for an adult over the age of 18. We also note that since this amendment, the majority of psychiatrists have nevertheless continued to provide the Tribunal with a second opinion, and indicated that they feel more comfortable with this practice. We therefore propose the MH Act be amended to reinstate the requirement of a second opinion to uphold the first before ECT can be considered by the Tribunal. This would also be consistent with Principle 16 of the *UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care*, which requires a second opinion from a mental health practitioner in cases of treatment through admission to a mental health facility. We understand that this is also the preference of key consumer and carer groups.

Our second concern around the practice of ECT is the question of oversight of private facilities in the ACT e.g. Hyson Green. The PA does not have oversight of these facilities and our understanding is that they are not required by law to notify any external agency when they are proposing ECT for a mental health consumer in their facility. We became aware of a woman with borderline personality disorder (BPD) who is a regular consumer of the public mental health system and strongly connected to our services with a long term case manager in one of the community mental health teams. She recently checked into Hyson Green and was given multiple sessions of ECT, which is not usually a recommended treatment for BPD. This raised concerns, particularly as private facilities do not need to notify us or provide justification for this choice of treatment. We would strongly recommend this absence of oversight be reviewed to ensure adequate protection of vulnerable mental health consumers.

Finally, we recently became aware of an application for emergency ECT before ACAT, in which the ACAT agreed to the initial 3 sessions of ECT. The applicant also wanted to apply for a non-emergency ECT order, but as this required a notice period of 3 days, the ACAT was unable to deal with that application at the same time. We would suggest consideration be given to providing the ACAT limited discretion to waive that requirement in certain circumstances.

### *Increased Autonomy for Consumers*

It is unfortunate that the main focus of the mental health system in the ACT is one of crisis intervention. With reduced resources and an ever growing demand on an already over-burdened sector, it is imperative that we find a way to work more strategically with the resources at hand. The spirit of the new MH Act, though admirable, cannot reasonably be met in our current under-resourced system. We are forced to

choose between early treatment and intervention and crisis management of the chronically mentally unwell population. This obliges those in the system to apply a risk-based approach.

Some of the new provisions in the MH Act focussing on promoting autonomy are the Nominated Person, Advance Agreement and the Advance Care Agreement forms. Since the PA receives all notifications related to involuntary detention under the MH Act we have observed very little uptake of these provisions. In an attempt to address this deficit, the PA is directly contacting those mental health consumers about whom we have received notifications of revocations or withdrawals of involuntary orders. We are mailing out an explanatory cover letter and including the package *'My Rights My Decision'* which is inclusive of the above-mentioned documents. We consider this to be an effective catchment point for those consumers who have likely been assessed as currently having sufficient decision-making capacity to collaborate with their treating team in completing these forms and have them uploaded for easy reference should they become unwell again in the future.

It is also worth mentioning that we must be mindful that decision-making capacity is decision-specific, and that, with support, an unwell mental health consumer may still have the capacity to complete a Nominated Person form even while an inpatient in a mental health facility. Supported decision-making must always be attempted to ensure the consumer's rights are upheld. Having a nominated person is helpful to both the treating team and the consumer, and must be utilised if at all possible.

#### *Adolescent Care*

Another significant issue that was flagged by our office is the need to have some legislative guidelines for seclusion and restraint, particularly for children and adolescents. We became aware that young people were being secluded and restrained in a medical ward where the nursing staff were not trained in mental health and were not aware that they had to record these incidents and notify the PA. As medical wards are often used as overflow or as an alternative to placing a young person in our adult mental health unit (AMHU), it became obvious to us that this needed to be addressed urgently. The HRC areas of the PA and the Health Services Commissioner have been working extensively with ACT Health to progress the Safe Wards project. Accordingly, we strongly recommend that the legislation be amended to provide a clear legislative base around seclusion and restraint of children and young people including appropriate safeguards.

A related issue involves children and young people with disability, such as autism or intellectual disability, who are being restrained or secluded while in CHS facilities where it appears there is no appropriate legislative basis for that restraint or seclusion. In some cases, while orders may be sought and granted, we understand that the children and young people may not have a mental illness or mental disorder as defined under the MH Act. As such circumstances may involve misapplication of the MH Act, we are working with ACT Health to address these concerns. Our experience in circumstances of some children and young people having comorbidity of mental health and a different disability, such as intellectual disability or autism, has been that there is limited expertise available and involved in decision making about how to provide an appropriate therapeutic response to these complex needs without the use of restraint or seclusion.

#### *Aboriginal and Torres Strait Islander Cultural Rights*

We note that the MH Act is generally silent about the cultural rights and cultural safety of Aboriginal and Torres Strait Islander mental health consumers, although s 6 (Principles) does refer to a person receiving services that are sensitive to their culture. We suggest, consistent with its obligations under the HR Act, particularly the cultural rights protected in s 27(2) of the HR Act, that Mental Health ACT should ensure it is using culturally safe practices, including through specific policy and procedures. The objects and principles of the MH Act also already cite a number of rights relevant to consumers that are also protected in the HR Act. It may further highlight the importance of Aboriginal and Torres Strait Islander peoples' cultural rights by

adding explicit mention of them in section 5 or 6 of the MH Act, or at least cross-referencing to s 27(2) of the HR Act.

### *Role of Carers*

The MH Act included new provisions to address carers being provided information about consumers by the treating team. For example, the principles in s 6 include that services should facilitate appropriate involvement of close relatives, close friends and carers in treatment, care or support decisions in partnership with medical professionals. Section 15 also requires that mental health facilities keep carers informed about a person’s treatment and rights. The Commission has received complaints about treating teams not involving carers in treatment decisions, and not adequately keeping carers informed. Again, we recommend that further training be provided to clinicians to ensure they are meeting the requirements of the MH Act.

### **Next Steps**

We note the MH Act was developed using a review advisory committee comprising many stakeholders including consumers and carers. We suggest a useful outcome of this process might be to convene at least a single meeting of such stakeholders to discuss the current operation of the MH Act.

Yours sincerely



Dr Helen Watchirs OAM

Jodie Griffiths-Cook

Karen Toohey

Heidi Yates

President and Human Rights Commissioner

Public Advocate and Children and Young People Commissioner

Discrimination, Health Services, and Disability and Community Services Commissioner

Victims of Crime Commissioner

25 June 2019