



Submission:

Review of the ACT Mental Health (Treatment and Care) Act 1994 – Second Exposure Draft

Submitted via email to:
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ACT Mental Health Consumer Network Submission

This submission has been prepared by the ACT Mental Health Consumer Network in response to the release for comment of the Second Exposure Draft of amendments to the *Mental Health (Treatment and Care) Act 1994*. The submission is in addition to comments provided to ACT Health in forums and individually by Network members.

The Network is the peak body for mental health consumers in the ACT. Run by consumers for consumers, our aim is to advocate for services and supports for mental health consumers which better enable them to live fuller, healthier and more valued lives in the community. We do this through advocacy, representation, lobbying and active involvement in new developments in the mental health sector, as well as in the wider health and community sectors.

General Comments

The Network is pleased to have the opportunity to comment on this second Exposure Draft. We thank the Health Directorate for again holding forums and hearing from mental health consumers directly.

The Network is pleased to see that the majority of changes to the first Exposure Draft recommended by the Review Advisory Committee have been incorporated, to a greater or lesser extent. We generally support these changes. For example, we are very pleased that the draft incorporates terminology changes recommended by the Review Advisory Committee, such as substituting 'mental disorder' for 'mental dysfunction' and 'has impaired decision making capacity' instead of 'does not have decision making capacity'. We are also pleased with the revisions to the provisions for making Psychiatric Treatment Orders (PTOs) and Community Care Orders (CCOs) which more clearly limit the circumstances in which a capacitous consumer's decision not to consent to particular treatment can be overridden.

However, there remain areas in which we believe the 2nd Exposure Draft does not appropriately protect the human rights of mental health consumers.

In particular, we are concerned that the forensic provisions are difficult to comprehend and do not contain adequate safeguards and respect for an individual's rights. Further, they appear to give the ACAT power to make orders more properly made by a court and to place people in what amounts to preventative detention in a correctional facility with no proof of crime or criminal behaviour.

The Network also notes the importance of information and education if the amendments are to be effective. Information and education materials should be developed in consultation with consumers, who should also be involved in their delivery. The experience of training police through the community policing initiative has strongly

demonstrated the value of those who exercise functions under the Act hearing directly from those affected by those actions.

Specific Comments¹

Drafting

We are pleased to see the reorganisation of provisions so that provisions dealing with rights of individuals and provisions dealing with advance agreements are before provisions about making orders. However, the Network is disappointed that the drafting of much of the 2nd Exposure Draft is ambiguous or unwieldy, and sometimes tortuous, resulting in legislation that is unclear.

Small things make legislation much harder to make sense of for those who are meant to interpret and apply it, as well as for those whose liberty may be taken away under its provisions. Some simple drafting changes would assist. For example, we understand the conventional approach to definitions in ACT legislation is for those used across the particular Act to be in the dictionary, and those used only in a section of part to be included in that section or part. However, while some definitions in the 2nd Exposure Draft are in the dictionary, others are placed at the start of a section, part or chapter, or at the end of a section, part or chapter, or sometimes the term is inserted within a section in parentheses. We would prefer that the approach be standardised so that definitions are always in either the dictionary or in one other consistent place in the section, part or chapter to which they apply, throughout the new Act.

Chapter 2 – Objects and important concepts

The Network supports the inclusion of the objects relating to families and carers.

The Network is disappointed that the principle that a person must be assumed to have decision making capacity only applies, on the face of it, when an individual's decision making capacity is being specifically considered. This is the result of including the assumption of capacity in principles that apply to consideration of capacity.

This is a fairly circular approach, which undermines the importance of the assumption of capacity. The Network would like to see paragraph 8(1)(a) moved into section 6, so that it is clearly a principle that applies in every case when a person is exercising a function under the Act.

Chapter 3 – Rights of people with mental disorder or mental illness

The Network supports the re-ordering to place these important provisions earlier in the Act. We note that a regulation prescribing a statement of rights is to be developed, and ask that we be consulted in the development of the regulation.

¹ All references to provisions are to the numbering in the Mock Up released with the 2nd Exposure Draft.

We note that the provision no longer refers to the right to obtain legal advice and the right to obtain a second opinion as rights to be included in the statement of rights. The Network is keen to ensure that they continue to be included in the prescribed rights and notes that the statement of rights to be prescribed is not limited to rights under the Mental Health Act.

Advance Agreements

We are pleased that there has been some clarification of these provisions, and support elements such as the continuing effect of an Advance Agreement (AA) when a person does not have decision making capacity. We also agree that this must be balanced by an individual's views at a later point when their decision making capacity is impaired. So we support the general approach that mental health professionals are bound by an AA, but that where the person is unwilling to receive treatment, the legal consent provided by the AA does not extend to the use of force. In these circumstances, we agree that it is appropriate to seek an order from the ACAT.

However, the drafting of the AA provisions remains unclear and leaves a number of ambiguities. The Mental Health Policy Unit has advised that further drafting is being done on these provisions. The Network should be consulted on these provisions before they are introduced.

Some of the issues relating to AAs that the Network believes remain unclear in the 2nd Exposure Draft are:

Membership of the treating team and role of representative member:

The Bill provides that an AA is an agreement between the consumer and the 'treating team' (s.20). This agreement is evidenced by the signature of the 'representative' who is nominated by the treating team (s.19 definition). The AA may be amended by agreement with the treating team, evidenced by signature of the representative.

However, it is not clear who would constitute the treating team at various times. Does the AA need to state the members of the treating team when it is made? Do all members of the treating team need to actively nominate or agree to the selection of a representative? If a consumer wishes to amend their AA, can the treating team who must agree, under s23, be different to the team at the time the AA was signed off? Does there need to be a new nomination of the representative if membership of the treating team changes? The Network is concerned that the concept of a 'treating team' and the treating team's nomination of a representative has still not been adequately addressed and is unclear.

In addition, it is not clear what, if any, role the consumer may have in deciding who makes up the treating team. Can a person specify that a particular mental health professional is not to be a member of their treating team?

Given the importance of the agreement with a treating team, it is important that these issues be clarified.

Can an AA set out that a person does not consent to particular treatment?

We understand one intended effect of the provisions to be that a person may state, in an AA which has been agreed to and signed by the representative member on behalf of the treating team, that they do not consent to certain treatment. That would then be binding upon mental health professionals, and can only be overridden by an order from the ACAT.

However, s.20(1) only provides for an AA to set out a person's 'preferences' and s.21, in setting out the possible contents of an AA, refers to a person's wishes rather than consent in relation to treatment. The section refers to consent, and specifies that the AA can include whether the person consents, only in relation to seeking views from family members or carers (paragraph 21(d)).

This makes it unclear what the status of 'wishes' is, but the use of 'consent' in paragraph 21(d) seems to imply that a person cannot effectively specify in an AA that they do or do not consent to particular treatment. Provisions that require mental health professionals to act in accordance with the agreement are significantly weakened if consumers cannot clearly and unambiguously state that they *do or do not consent* to specific treatment in an AA.

The Network believes that s.20 should be amended to clearly state that the contents of an AA may include

- a. the ways in which the person consents to be treated or cared for; and
- b. the ways in which the person does not consent to be treated or cared for, including specific medications the person does not consent to

The AA should still be able to set out preferences and wishes as well as specifying consent and lack of consent.

Duration of AAs

We understand s.22 to be intended to mean that an AA usually ceases to have effect at the end of 12 months. We request that the drafting be clarified to refer to when the AA ceases to have effect. We are also concerned that the relationship between sections 22 and 23 is unclear. Does the 12 month period restart when an agreement is amended, or does the amended agreement remain in force only for 12 months from the date of the original agreement?

In addition, the ability to continue treatment under s.27 after the AA has ended at the end of 12 months is unlimited, so that as long as the person does not actively object to the treatment it could continue indefinitely. We suggest that there should be a time limitation, not more than another six months, beyond which it is not appropriate to continue treatment under an AA which is no longer in force under s.22.

Relationship with guardianship and powers of attorney

The Network is concerned that appointment provisions for people such as guardians and attorneys under a power of attorney override an AA, without its contents having been considered. We believe that guardians should also be bound by an AA which is in effect, so that they cannot consent to treatment inconsistent with the AA. This should remain a matter for the ACAT to consider. In the case of attorneys, we suggest that only an attorney appointed *after* the AA was made should be able to override it. Where entering an AA is the most recent action taken by a person, it should prevail.

The Network is also concerned about section 29, which we believe needs to be reconsidered. It appears to have the effect that a guardian is not required to act in accordance with an AA. We do not consider it sufficient for the guardian simply to take an AA into account, and record reasons for departing from it.

The Network believes that a guardianship appointment should not be made without consideration of the terms of any AA, and an appointment *inconsistent with* the AA should only be made in exceptional circumstances. S.29 needs to be reconsidered and clarified, and an amendment to the Guardianship Act may be required to ensure that the existence of an AA, and its terms, are considered before an appointment is made.

Emergency Detention

There are very mixed views among consumers about allowing the ACAT to order a longer period of emergency detention. The Network acknowledges that an application to extend emergency detention for more than 3 days can only be made where the chief psychiatrist believes on reasonable grounds that the person has impaired decision making capacity relating to treatment decisions (s.80(2)). This limitation is critical to our acceptance of this provision.

Nevertheless, the 18 month period of review of this provision is also critical. The Network will be keen to see the data on whether there is a reduction in applications for longer term orders through use of longer emergency detention.

The Network is concerned that the provision requiring review of the maximum period of emergency detention and reporting to the Legislative Assembly does not appear to have been included in the 2nd Exposure Draft. We cannot support the extended period unless there is a clear legislative requirement for it to be reviewed no later than 18 months after its commencement and the report made public.

Forensic orders

The Network is concerned that the forensic provisions are very difficult to follow, appear to significantly infringe on individual liberties in circumstances where people have not gone before a court, and may be internally inconsistent.

For example, s.89 enables the chief psychiatrist for a forensic psychiatric treatment order, or the relevant person for a forensic community care order, to apply for a forensic mental health order in relation to an alleged offender. An alleged offender is defined in the dictionary in a very broad way, including someone who has been neither arrested nor charged with any offence. S.89 requires that the chief psychiatrist (or relevant person for a forensic CCO) form a view about the appropriateness of prosecution – something which we consider is properly a matter for the police and Director of Public Prosecutions, or a court.

S.97 enables the ACAT to make a forensic PTO in relation to the categories of people set out in s.97(1). It appears to us that this is narrower than the definition of alleged offender, in that paragraphs 97(1)(a) and (b) refer to people who have been convicted of an offence, and those referred to in s.97(1)(c) appear to have had charges considered by a court.

We seek clarification as to whether ACAT can make a forensic PTO for an alleged offender who has not been charged with an offence, or has merely been arrested, and so presumably does not fall within any of the categories in s.97(1). We also believe the current definition of alleged offender to be too broad and should be revised.

No matter how the ambiguity between the use of ‘alleged offender’ and the criteria for making an order is resolved, we are not convinced that there are any circumstances in which the ACAT should be able to order a person, particularly one who has not been convicted of a relevant offence nor found unfit to plead, to be held in a correctional facility. Imprisonment in correctional facilities is a matter for the courts and the criminal justice system. The presumption of innocence should not be lost simply because a person has mental disorder or mental illness.

Should it be considered necessary for the ACAT to have such a power of preventative imprisonment at all, then the circumstances in which it can be ordered need to be much narrower and relevant facts should be proved to a high standard.

We would like to see significant revision of the forensic mental health provisions.

Support of other submissions

The Network generally supports the submission by the Mental Health Community Coalition of the ACT.

In particular, we support MHCC’s suggestion of a statement of reasons when assessing a person’s risk of harm to self or others. The Network echoes MHCC’s concerns that there currently appears to be too much weight placed upon risk, and not enough on a person’s capacity to effectively make decisions.