



FRAMEWORK PAPER

The review
of the
**ACT Mental Health
(Treatment and Care) Act 1994**

**The Framework of Mental
Health and Related
Legislation in the ACT:
An Options Paper**

November 2009

Acknowledgement:

This paper has been prepared by Maree Livermore,
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Table of Contents

Abbreviations	4
Executive Summary	6
PART I: INTRODUCTION	6
The purpose of this paper	6
About the Review.	6
Who's who in the Review?	6
The Review to date.	6
The new Stage 3 consultation	7
Elements of the Framework.	7
What law is involved?	7
Why consider the whole framework?	8
Principles.	8
PART II: MENTAL HEALTH LAW FRAMEWORK OPTIONS.	11
Introduction.	11
Framework Option A: The current arrangement of the law	11
Description of the basic model	11
Possible variations	11
Reflection of mental health law principles	12
Other pros and cons	13
Framework Option B: Current arrangement of the law, but with mental dysfunction removed from mental health law.	14
Description of the basic model	14
Possible variations	14
Reflection of mental health law principles	14
Other pros and cons	15
Framework Option C: Capacity-based law.	16
Description of the basic model	16
Possible variations	17
Reflection of mental health law principles	17
Other pros and cons	18
PART III: OTHER STRUCTURAL ISSUES	19
The definitions issue	19
Diagnosis as a structural element	19
Longer-term detention of consumers with mental dysfunction conditions.	19
Dual disability and dual diagnosis	20
Preventive detention	20
Placement of forensic provisions	21
Who are forensic mental health consumers?	21
Ease of use.	21
Stigma	21
Parity	21
Balancing rights and interests	22
Restrictive practices	22
What are restrictive practices?	22
Why are they an issue?	22

Other problems in guardianship	22
Lack of ‘coercive powers’	22
No psychiatric treatment under guardianship	23
Treatment under the Framework Options	23

Appendices

Appendix A	24
Appendix B	24
Appendix C	25
Appendix D	26
Appendix E	27
FEEDBACK FORM.	28

Abbreviations

DSA	<i>Disability Services Act 1991</i>
GA	<i>Guardianship and Management of Property Act 1991</i>
CCO	Community Care Order
HRA	<i>Human Rights Act 2004</i>
MHA	<i>Mental Health (Treatment and Care) Act 1994 (ACT)</i>
MHT	<i>ACT Mental Health Tribunal</i>
MTHDA	<i>Medical Treatment (Health Directions) Act 2006</i>
PAA	<i>Powers of Attorney Act 2006</i>
PTO	Psychiatric Treatment Order

How to lodge a submission

Interested parties are invited to lodge written submissions via post, email or facsimile.

Postal Address

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The closing date for submissions is 29 January 2010.

Executive Summary

The ACT's *Mental Health (Treatment and Care) Act 1994* forms a principal part of a system, or framework, of separate pieces of legislation that together provide for decision-making in respect of certain vulnerable residents of the ACT. Other legislative elements of the framework include:

- the *Guardianship and Management of Property Act 1991*
- the *Disability Services Act 199*
- the *Medical Treatment (Health Directions) Act 2006*
- the *Powers of Attorney Act 2006*, and
- the *Criminal Code 2002*, in relation to forensic mental health.

The populations covered by the laws forming part of the framework include people with mental illness, people with mental dysfunction conditions and people who have impaired mental capacity.

The interaction, if not interdependence, of these items of legislation has become clear in the course of the current review of the *Mental Health (Treatment and Care) Act 1994*. A number of options have emerged for addressing the framework overall. This Options Paper outlines three basic sets of 'Framework Options'. These are:

- *Framework Option A*: Retain the current arrangement of the law
- *Framework Option B*: The current arrangement, but with removal of mental dysfunction from the mental health law.
- *Framework Option C*: Introduction of a capacity-based law

Possible variations consistent with the overall tenor of each Framework Option are also outlined.

Part II of the Paper explains the operation and extent of change to the current law represented by the scheme for legislation proposed under each Framework Option. There is brief analysis and, to an extent, a comparison, of each Option by reference to the mental health law principles of benefit, protection and human rights. A number of additional pros and cons for each Framework Option are also outlined.

The modelling of the Framework Options has been performed with a view to specific structural issues that have emerged in the course of the current review. These include:

- The lack of a clarity and consistency in the legal definitions concerned with mental capacity
- The location and rationale for provisions for involuntary interventions for groups considered to fall within the definition of mental dysfunction (which include people with cognitive disorders, developmental disorders, substance-related disorders, brain injury and intellectual disability)
- The location of provisions relating to forensic mental health
- The prevalence of dual disability and dual diagnosis
- Variation in stakeholders' views about preventive detention
- The regulation of restrictive practices
- Problems with the ACT's existing guardianship law

Stakeholders are invited to consider the treatment of these issues in the context of the Framework Options provided, and to indicate their preferences for a Framework Option overall. Indeed, this 'Framework' Options Paper is intended to form the basis of a new Stage 3 Consultation phase for the review. Stage 3 consultation will include the solicitation and analysis of written submissions in response to this Paper, and face-to-face consultation with stakeholder groups. The contributions gained during consultation will be strongly factored into the ACT Government's decision-making on a direction for positive and workable change to the ACT's framework of mental health and related legislation.

Part I: Introduction

The purpose of this paper

The ACT is currently involved in a review of its mental health legislation. The ACT Government has identified a range of options for the framework for the revised law.

It is intended that this Options Paper form the basis of community consultation in relation to legislative framework. This consultation will assist the Government in its choice of a conclusive direction for the mental health law reform process in the ACT.

Part II of this Options Paper explains the range of options for the revised framework and how each relates to basic principles of mental health care law. Part III describes other important structural issues in the Review.

About the Review

The Review of the *Mental Health (Treatment and Care) Act 1994* (the MHA) commenced in 2006. The purpose of the Review is to ensure that the mental health law, as it applies in the ACT, reflects best practice in mental health law. The characterisation of best practice is influenced by the current needs and values of the ACT community in seeking to protect, promote and improve the lives and mental well-being of its citizens.

Who's who in the Review?

The Review is a jointly managed by ACT Health and the Department of Justice and Community Safety.

The ACT Mental Health Act Review Advisory Committee (referred to here as 'the Committee') will make recommendations to the ACT Government about how the law should change.

The Committee includes people from the ACT Government and community agencies involved in mental health and disability services, people involved in the law, and consumers of mental health services.

The Secretariat for the Review is managed by the Mental Health Policy Branch within ACT Health. There is a consultant appointed to conduct and report on consultation with stakeholders, and to make recommendations and respond to the Committee in relation to its investigation of the issues.

The Review to date

Early community consultation in the Review identified a wide range of issues for attention – from practical matters around the powers of ambulance workers, to issues of human rights, and the coverage of consumers with 'mental dysfunction' conditions.

A preliminary range of options on these issues was presented in an Options Paper released by the Attorney-General and the Minister for Health in November 2007. There were further consultations (called Stage 2 consultation) on the issues raised in this document.

Around the same time, a Forensic Mental Health Working Group, on instructions from the Committee, commenced a more detailed investigation into options for the forensic mental health issues in the Review. (Forensic mental health law deals with the special processes and considerations involved when a person with a mental illness or a form of mental dysfunction becomes involved with the criminal justice system.)

The Committee considered the results of the Stage 2 consultation in April 2008. It decided that there

were some fundamental issues that needed to be resolved before others could be properly addressed. The Committee requested that the consultant conduct further research into these structural issues. The results were presented to the Committee in December 2008.

It is possible now to articulate a range of possible models for the reform of the ACT's mental health and related legislation.

Stakeholders are also invited to consider the Forensic Mental Health Options Paper that is released at the same time as this Paper. Although the issues set out in this paper represent important threshold matters for the Review, the committee has come to the view that consultation on forensic mental health issues is appropriate given the complexity of the issues.

The new Stage 3 consultation

The Government now seeks ACT community input and opinion on the options for the basic framework for mental health and related legislation in the ACT through a new consultation process, to be known as Stage 3 consultation. The results of the consultation will be reported to the Committee. The Committee will make a recommendation to Government. The Government will carefully consider the views of the Committee and the community generally and make a decision about the model to be pursued. The focus of the Review will then return directly to other identified issues in preparation of an Exposure Draft of the updated legislation.

How to lodge a submission

Feedback, comments and submissions in relation to the issues raised in *The Framework of Mental Health and Related Legislation in the ACT: An Options Paper* may be of any form or length. You may choose to use the Feedback Form provided at the back of this document.

Interested parties are invited to lodge written submissions via post, email or facsimile.

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Elements of the Framework

What law is involved?

The law that applies in the ACT to the treatment, care and involuntary decision-making in relation to people with mental illness and mental dysfunction is not a single law but rather a system of interdependent pieces of legislation.

The principal element in the system is the *Mental Health (Treatment and Care) Act 1994* (the MHA). The current MHA provides for involuntary treatment and care of people found to be suffering from **mental illness** and also for those who have a form of **mental dysfunction**. 'Mental dysfunction' is a

term that is broadly defined in the MHA. It incorporates conditions such as intellectual disability, acquired brain injury, cognitive disorders (such as dementia), developmental disorders (such as autism), behavioural disorders (such as ADHD) and substance-related disorders (such as alcoholism). The MHA includes much of the ACT's existing law about forensic mental health.

Other related pieces of legislation include:

- The *Guardianship and Management of Property Act 1991 (the GA)*; the *Power of Attorney Act 2006 (the PAA)* and the *Medical Treatment (Health Directions) Act 2006 (the MTHDA)*. These laws provides for aspects of substituted decision-making for people who have 'mental impairment' and are unable to make their own decisions.
- The *Criminal Code 2002*. The Criminal Code includes the defence of mental impairment.
- The *Crimes Act 1900*. The Crimes Act provides for decision-making for persons who are held to be unfit to plead or not guilty by reason of mental impairment.
- *Children and Young People Act 2008*. This Act provides for referral of children and young people who become involved with the criminal justice system into mental health treatment and care.
- The *Disability Services Act 1991 (the DSA)*. The Disability Services Act provides for funding of disability service providers.

In addition to the law established by pieces of legislation enacted by the Assembly, the common law (law made by judges in our court system) also has strong rules about treatment and consent.

Why consider the whole framework?

The phrase 'mental health law framework', as used in this paper, refers to the manner in which the total set of mental health and related provisions, that deal with substituted decision-making and involuntary interventions in relation to individuals with mental illness and mental dysfunction conditions, may be arranged across one or more pieces of law.

The Government recognises that it may not possible to amend the MHA without amending related legislation, or even creating new legislation. This is particularly the case when the existing 'catchment group' for the current MHA is as wide as it is (including some disability groups), and that service provision for the respective groups is sometimes interconnected. Furthermore, as discussed further in Part III of this paper, there are gaps and overlap between our existing systems for involuntary decision-making in relation to treatment and care under the MHA, and for substituted decision-making under the GA and PAA.

Principles

A number of principles of law-making and governance come into play in considering possible directions for reform of the law in this area. These are the same principles that have underpinned mental health law-making throughout Australia and around the world for many decades. They are:

To provide benefit to the individual suffering from mental illness or with a mental dysfunction condition.

This principle requires the law to optimise access to health and ancillary services for consumers, to promote mental health, to prevent ill-health and to facilitate recovery.

To protect vulnerable people.

It is considered an important responsibility of government that consumers suffering from the effects of mental illness, or dealing with the consequences of a mental dysfunction condition, should be protected in their vulnerability from external forces (either other people or conditions in society) that could harm them.

It is the case also sometimes that vulnerable individuals need protection from self-harm.

To protect the community

Government acknowledges a responsibility to protect the community from the harm or damage that is sometimes committed by a person who is suffering from the effects of mental illness or dealing with the consequences of a mental dysfunction condition. The protection of the carers, family members and service providers are a particular focus of this concern.

To honour intrinsic human rights

The *Human Rights Act 2004* (HRA) protects a number of civil and political rights of residents of the ACT. The HRA aims to create a culture of respecting and promoting human rights within the ACT.

People with mental illness and mental dysfunction conditions have the same human rights as others in the ACT community. In particular, the HRA protects the right of people with mental illness and mental dysfunction conditions to equal treatment before the law, the right to liberty and security of person and the right not to be subjected to medical treatment without free consent. These rights are subject only to the reasonable limits in law that can be demonstrably justified in a free and democratic society.

The interpretation of the HRA and human rights in the ACT will be guided by international law. In international human rights law, people with mental illness and mental dysfunction conditions have rights to self-determination, bodily integrity and personal freedom.

It is relevant to note that Australia is a recent signatory to the *United Nations Convention on the Rights of Persons with Disabilities*. By ratifying the Convention, Australia has committed to enact laws and take other measures to improve disability rights, and also abolish legislation, customs and practices that discriminate against persons with disabilities. The first of the principles for the Convention, stated at Article 3, is ‘respect for inherent dignity, individual autonomy, including the freedom to make one’s own choices, and independence of persons.’

Other sets of principles include the Ten Basic Principles for Mental Health Law formulated by the World Health Organisation in 1996, listed in Appendix A. The WHO instrument ‘aims to depict basic principles for the field of mental health with as little influence as possible from given cultures or legal traditions’. Having identified a ‘neutral’ set of principles, the WHO suggests that they should be then be embodied into the law of a place in a manner that suits local requirements.

It is recognised that it is not possible for the law to represent all of the principles equally. Some of them – for example the rights of the individual and the rights of the community – will, on occasion, conflict.

The ACT Government is now calling on the ACT community to provide its views on how the relevant principles should be reflected in the choice of a framework for ACT mental health law.

Treatment of ‘mental capacity’

The definition and role of the concept of the ‘mental capacity’ of the consumer has been identified as an area for possible reform within the mental health law framework. As will be seen in Part II, the mode of treatment of the mental capacity issue clearly distinguishes some of the options for changes to the framework overall.

How should it be defined?

In considering these, it is important to keep in mind that the notion of mental capacity in popular usage differs from legal concepts of mental capacity, and further, that there are currently several legal definitions of mental capacity in operation.

Even within the ACT's mental health law framework, there is no single, consistent legal definition to assist with the assessment of a person's mental capacity. The MHA refers to 'capacity' but provides no definition to guide assessment by either the Tribunal or medical practitioners. The GA refers broadly to 'impaired decision-making ability'. The PAA and the MTHDA define 'impaired decision-making capacity'. The Criminal Code refers to 'mental impairment' for specific forensic mental health purposes.

Legal concepts of mental capacity applying within the mental health law framework must be further distinguished from legal concepts of capacity related to legal maturity (e.g. the age of consent) and from legal capacity based on citizenship status.

A possible definition of mental capacity suitable for use in the mental health law framework in the ACT is set out at Appendix B.

What role should mental capacity play?

In mental health and related legislation, an assessment of a person's mental capacity is used to inform service providers, the courts and others about whether a person can make their own decisions about medical treatment, care, residence and personal and financial affairs, or whether a substitute decision-maker (e.g. the Tribunal, a guardian, the Chief Psychiatrist) should become involved.

The treatment of mental capacity in the options for amending the framework for mental health and related legislation in the ACT, as set out in Part II of this paper, differs in the importance afforded to the mental capacity factor in deciding whether an involuntary (substituted) decision-making process will be brought into effect.

Part II: Mental Health Law Framework Options

Introduction

There are three basic options for the structure of ACT mental health and related law arising out of the current Review. These are:

- *Framework Option A*: The current arrangement of the law
- *Framework Option B*: The current arrangement, but with removal of mental dysfunction from the mental health law.
- *Framework Option C*: Capacity-based law

Each Framework Option is described in detail below, along with a description of possible variations consistent with the overall scheme.

Framework Option A: The current arrangement of the law

Description of the basic model

Under ACT law currently there is a stand-alone mental health law (the MHA) that provides for involuntary assessment, treatment, care and detention of people who have a diagnosis that is covered within the definition of either mental illness or mental dysfunction, and to whom one or more of a set of criteria focussing on risk of harm to self or others applies. Provisions applying to forensic mental health consumers are included.

There is separate guardianship law (the GA) that provides for substituted decision-making in the best interests of a person assessed to have impaired decision-making ability. The processes of the guardianship law can apply to decisions about property, finances, residence, education, employment, aspects of legal proceedings and medical treatment, with the exception of certain prescribed treatment (which include psychiatric treatments). A guardian cannot make a decision that is contrary to a determination made under an order under the MHA, or provide consent on behalf of a person to psychiatric treatment.

There is a disability services law (the DSA), that deals exclusively with processes in relation to funding of community-based disability services providers.

New in 2006, a health directions law (the MTHDA) establishes that an adult may make a written 'health direction' to refuse or require the withdrawal of unwanted medical treatment. A valid health direction binds the decision-making scope of any guardian subsequently appointed.

The ACT's power of attorney law (the PAA) enables a person who possesses decision-making capacity to appoint an attorney to act for them in property, financial or personal care matters in the event that the person no longer possesses decision-making capacity.

Under Framework Option A, the existence and basic arrangement of these laws would be retained.

Possible variations

Variations of Framework Option A that are consistent with retention of the basic model include the following:

To modify of the risk of harm criteria. Expressions of the risk of harm criteria within the law of other jurisdictions, nationally and internationally, vary in their terms, most particularly in their specification of the likelihood of the risk required, and of the seriousness of harm envisaged, to engage the involuntary provisions. The effect of varying the qualifying terms is to either enlarge or reduce the scope of coverage of the criteria (i.e. higher thresholds of risk and harm reduce the number of eligible consumers).

To remove forensic provisions to a separate Act. See Part III for detail about the issue of the location of the

law dealing with forensic mental health consumers.

To amend guardianship legislation to include coercive powers. See Part III for more about some of the difficulties of the existing guardianship legislation.

To introduce a capacity criterion. Without changing the basic arrangement of the legislation, it would be possible to factor criteria in relation to mental capacity into the criteria for coverage of the existing MHA. (See Framework Option C for more about mental capacity.)

Reflection of mental health law principles

Principles relating to protection

Framework Option A is characterised by ‘wide coverage’ – by virtue of the inclusion and width of the mental dysfunction definition, and the low threshold both of risk and of possible harm. In that the range of consumers eligible for involuntary orders is wide, Framework Option A is, as compared with the other Options, relatively strong on the protection principles – both in relation to consumers and the community.

Principles relating to benefit

The width of coverage under Framework Option A enables provision of services for the benefit of consumers on broad base across the population.

Conversely, it has been claimed that the risk of harm criteria creates a barrier to access for service and for early intervention in particular.¹ It has been suggested also that the emphasis on involuntary intervention within legislation and the public health system discourages provision of access to services sought voluntarily, and damages the therapeutic relationship.²

Principles relating to protection of human rights

Action open to ACT public authorities under Framework Option A to assess, treat, care for and detain a consumer without their consent potentially engages a number of rights set out in the ACT’s HRA³ including the prohibition against medical treatment without consent, the right to freedom of movement and choice of residence, and the prohibition against deprivation of liberty. Under clause 28 of the HRA:

human rights may be subject only to reasonable limits set by Territory laws that can be demonstrably justified in a free and democratic society.

There have been no legal proceedings in the ACT challenging the reasonableness of or justifications for the limitations on human rights engaged by the MHA. In some cases overseas however, in relation to human rights legislation where similar limitations apply, courts have preferred medical opinion about the desirability of involuntary intervention to ensure therapeutic benefit for and protection of consumers, and the protection of other persons with whom the consumer comes into contact, over human rights considerations. In *Herczegfalvy v. Austria*,⁴ the court declared that it should be: for medical authorities to decide, on the basis of recognised rules of medical science, on the therapeutic methods to be used, if necessary, by force, to preserve the physical and mental health of patients.

1 Ryan, C. Large, M. Nielssen, O, and Hayes, R 2008. *A proposal to alter the criteria for non-voluntary treatment of the mentally ill as part of the Review of the Australian Capital Territory Mental Health (Care and Treatment) Act 1994*. Submission to the Review of the ACT Mental Health Act dated 23 January 2008.

2 Tasmanian Department of Health and Human Services 2007. *Review of the Mental Health Act 1996: Discussion Paper*. August 2007.

3 e.g. *Human Rights Act 2004* (ACT) ss 10(2), 13, 18(1) and (2).

4 24 Sept. 1992 (No.15) EHRR 437 (1993)

The MHA itself currently states that its objective is to provide benefit and protection that is ‘least restrictive’ of human rights.⁵

There are a range of approaches to how an individual’s rights can be lawfully restricted by use of involuntary detention. On one view, the existing legal framework which applies to consumers diagnosed with mental illness or mental dysfunction lacks justifiability. This is suggested even though the power to make such interventions in the best interests of particular individuals may be reasonable and justifiable. See Framework Option C for more discussion on this point.

Finally, the detention of people with untreatable mental dysfunction conditions has been criticised as not falling within international best practice for mental health care.⁶

Other pros and cons

Pros

Considerable advantages flow from the status quo status of Framework Option A, namely in existence of relevant processes and stakeholder understanding, continuously refined over a number of years. Framework Option A involves the least amount of legislative change, and would require fewer resources to implement and inform the community about changes.

The wide coverage and emphasis on risk of harm criteria characterising Framework Option A, ensures that people with a mental illness or dysfunction who present as a risk to others, and who do have capacity with respect to effectively deciding their treatment, can be appropriately treated.

Of the three Frameworks, the wide coverage and emphasis on risk of harm criteria characterising Framework Option A provides the strongest legislative buffer against claims about the wrongful non-provision of mental health services resulting in harm.

Under Framework Option B (B1 at least), services are not provided to consumers with mental dysfunction on an involuntary basis. Under Framework Option C, services are not provided to consumers retaining mental capacity on an involuntary basis. (It remains an open question whether less involuntary service means less service.)

Cons

There are problems at the interface between our guardianship and mental health law works. See Part III for details.

5 Mental Health (Treatment and Care) Act 1994 s 7(a).

6 Watchirs H. (on behalf of National Rights Analysis Instrument Assessment Panel) 2000. *Application of Rights Analysis Instrument to Australian Mental Health Legislation: Report to the Australian Health Ministers’ Advisory Council, National Mental Health Working Group*

Framework Option B: Current arrangement of the law, but with mental dysfunction removed from mental health law

Description of the basic model

Framework Option B is essentially a development from Framework Option A, relying to a large extent on the existing pattern of inter-dependent pieces of legislation. The pivotal difference is that Framework Option B proposes the re-orientation of mental health legislation around the treatment and care needs of consumers with mental illness specifically.

This could be achieved in four ways:

- B1. by simply removing these provisions for longer-term treatment, care and support (including detention) of consumers with mental dysfunction conditions,
- B2. by moving them to another stand-alone piece of legislation such as a Disability Act,
- B3. by moving them to guardianship law, or
- B4. by inserting a new broadly-stated coercive power in guardianship law (which would give the guardian a general power to authorise involuntary intervention in the best interests of the consumer).

Possible variations

All of the variations listed under Framework Option A are consistent also with Framework Option B.

Reflection of mental health law principles

The extent of reflection of individual mental health law principles for Framework Option B differs as between the four sub-models.

Principles relating to protection

If the existing overall coverage of the mental health law is reduced by the exclusion of the mental dysfunction definition and related community care order provisions as proposed in B1, then it is arguable that protection of both the community and the consumer with mental dysfunction is reduced. If the existing detail of provisions is removed to other legislation, as proposed by B2 and B3, the principle of protection for both community and consumer is maintained at current levels. Under B4, the principle of protection for the consumer is supported, but the protection of the community is not.

Principle of benefit

A key element of the existing scheme is the Care Coordination Office, administered by the Public Advocate ACT. Under the direction of the Care Coordinator, the Care Coordination Office is responsible for overseeing the care and support of consumers with mental dysfunction who are placed on a Community Care Order.

Again, the value of Framework Option B in relation to the principle of benefit depends on the sub-model chosen. Under B1, it could be argued that the fact that mental dysfunction populations are not covered by provisions for involuntary treatment and care at all means that the principle of benefit is less overall for those consumers (if less involuntary service equals less service). If the care, support and accommodation options are provided specifically within a framework designed around best practice in appropriate service provision, and relevant law – as is envisaged at B2 and, to an extent, at B3 and B4 – it could be said that the principle of benefit for these consumers would be better supported in those sub-models than in B1 or in Framework Option A.

Principle of protection of human rights

Framework Option B attempts to relieve the inappropriateness of coverage of consumers with mental dysfunction under a medical model, as it is argued is currently the case under Framework Option A.

In general, however, Framework Option B engages human rights issues in the same manner as Framework Option A.

It is one view that the significant engagement of rights issues involved in the substituted decisions about involuntary treatment and detention under a broad catch-all power, under Framework Option B4, may be unwise. If this option were to be adopted, a detailed review of how the new power would function, and the scheme regulated, would need to be conducted.

In that Framework Option B1 releases mental dysfunction populations from any exposure to long-term involuntary action, it could be said that the potential human rights issues were minimised for that group under this sub-model. (A counter argument might be that in some circumstances a failure to engage involuntary action would breach a person's right to protection from cruel or inhumane treatment).

Other pros and cons

Pros

Framework Option B would bring the ACT into greater alignment with the rule of law, and most other Australian jurisdictions, in its treatment of populations with mental dysfunction conditions.

Cons

As for Framework Option A.

Framework Option C: Introduce a capacity-based law

Description of the basic model

A mental capacity law for all conditions and diagnoses

Framework Option C involves the creation of a new item of legislation – a mental capacity law – that would be, essentially, a fusion of our mental health and guardianship law.

The new law would provide a comprehensive structure for substituted decision-making applying equally to all individuals who lack mental capacity to make decisions about medical treatment, care, residence, and financial and personal affairs, regardless of their diagnosis. The law would apply, then, to people with mental illness, with intellectual disability and other mental dysfunction, to people with temporary or permanent mental incapacity resulting from medical conditions or substance abuse, and to people with ageing-related conditions affecting mental capacity.

A single, new definition of mental capacity

‘Mental capacity’ would be clearly defined in accordance with clinically recognised ‘domains of capacity’ approach. Refer to Appendix B for a possible formulation of a definition of mental capacity on this basis. The definition includes an additional requirement for ‘appreciation’ to ensure that insight into the true nature of any mental illness or mental dysfunction is pre-requisite. The presence of the requirement to ‘retain’ understanding would address issues in relation fluctuating capacity.

Mental capacity as a threshold criterion

Under Framework C, the absence of mental capacity, established on assessment, would be the initial, threshold criterion for engagement of the substitute decision-making provisions in the law. A possible formulation of the processes involved in early and interim stages is set out at Appendix C.

If a person was assessed to possess mental capacity to make the decision in question, the Act would not apply.

Longer-term substituted decision-making

Once the need for longer-term intervention was established, the interventions proposed to be undertaken for the consumer would need to be in the ‘best interests’ of the consumer, assessed on an individual basis. The considerations that might apply to the assessment of best interests in any particular case would be listed in the law. These could include risk of harm. (Even risk of harm to others might be relevant, if the avoidance of likely criminal or forensic mental health processes was seen to be in the best interests of the individual consumer.)

Where a person has been assessed as being unable to make a decision for themselves, under the law involuntary interventions determined to be in the interests of the person would be authorised irrespective of the consent or refusal of the consumer.

What decisions would be covered?

Decision-making in all life areas (property, finance, medical, legal, and other personal affairs) would be covered, including decisions in relation to psychiatric treatment. The processes applying would likely be grouped according to the seriousness of the intervention involved. See Appendix D for an indicative formulation of substantive intervention processes.

Interventions authorised under the Act could potentially range from the personal care assistance to serious surgical interventions.

There would be a range of possible substitute decision-makers, from a ‘person responsible’ to the Tribunal or court, depending on the decision context.

What would happen to the existing mental health and guardianship law?

There are two alternatives. Both the MHA and GA could be removed and replaced by a new mental capacity law. Alternatively, the MHA only might be removed and the existing guardianship law updated to effectively become the new mental capacity law.

To whom would the mental capacity law apply?

The impairment of mental capacity to make a decision can arise from many causes including dementia, intellectual disability, developmental disorder, stroke, brain injury, substance-abuse, mental illness, epilepsy, other disease affecting the brain, or as a result of a delirium or an unconscious state induced by any number of other 'physical' illnesses or injury, such as cancer, or even a high fever.

Notes on research in relation to the incidence of mental incapacity in populations of psychiatric and general medical in-patients are set out at Appendix E.

Possible variations

Variations of Framework Option C that are consistent with retention of the basic model include the following:

- To remove forensic provisions to a separate Act. See Part III for detail about the issue of the location of the law dealing with forensic mental health consumers.
- To make a separate mental health services law. To better recognise and regulate the role of non-government service providers in the mental health and disability sectors.
- To incorporate power of attorney law and health directions law into the new mental capacity act.

Reflection of mental health law principles

Principle of benefit

If less involuntary service is held to equal less service, it could be argued that less benefit is provided to the consumer population overall directly through the agency of Framework Option C, than say in Framework Option A. This is because Framework Option C envisages that consumers who retain mental capacity will not be covered by the Act and encouraged instead to access services on a voluntary basis.

On the other hand, it has been argued that where risk of harm is not a mandatory criteria, service is more accessible in circumstances where risk of harm is not an issue, or not yet an issue (for example, in the context of early intervention). There is no requirement to wait for the flowering of risk, only the identification of need, before involuntary intervention can take place. Risk of harm as a criterion can have the effect of narrowing the class of eligible consumers, whereas, by comparison, the combination of 'mental capacity' and 'best interests' provides for relatively wide catchment. Furthermore, the best interests basis could be seen to direct consideration to the benefit directly relevant to the individual whose needs are in question.

Principle of protection

In that Framework Option C enables self-determination by consumers where mental capacity is retained, the law itself provides less protection for both consumers and the community. In particular, it is acknowledged that capacity-based law, at least without adjusted criteria that accounts for the greater risk of harm, would be inappropriate for forensic consumers. This consideration supports the optional variation that would see provisions for forensic consumers addressed in a separate law.

Furthermore, in cases where a person with a mental illness is at risk of becoming involved in the criminal justice system because of aggressive or threatening behaviour, their care may need to be provided for through forensic provisions. This could occur even though they may not have been charged with committing a criminal offence.

Principle of protection of human rights

Framework Option C is formulated on the basis that involuntary interventions could be reserved for consumers who lack true mental capacity. Seen another way, consumer who retain true capacity to make decisions about their treatment and protection would be able to make those decisions, like other Canberrans with general medical conditions.

Framework Option C emphasises a 'level-playing field' for consumers who lack mental capacity, regardless of their diagnosis or cause of their condition.

In relation to the treatment of risk of harm criteria, there is no assumption of the relevance of risk to the full population of consumers with mental illness and mental dysfunction conditions. Instead, the need to protect against the flowering of risk of harm appears as one of a set of 'best interests considerations' that might apply in the individual case.

Framework Option C engages the same rights in the HRA as the other Framework Options. Where a person is unable to effectively make decisions with respect to their mental health, involuntary detention can be said to be more rationally connected with the limitation of those rights.

Other pros and cons

Pros

A mental capacity law would resolve conflict, gaps and overlap at the interface of the existing MHA and GA.

Framework Option C would allow for the fusion of the mental health and guardianship jurisdictions of the ACT Civil and Administrative Tribunal (ACAT) with multi-agency inputs allowing for integrated resolution of legal, medical, financial, behavioural management and mental health issues for individuals who lack mental capacity.

Cons

Mental capacity legislation covering consumers with mental illness is not yet in operation in any English-speaking jurisdiction. In this sense, if the ACT pursued Framework Option C it would be breaking new ground. There is a significant concern that the level of change involved in two systems (MHA and GA) of substituted decision-making for vulnerable consumers could have unintended and negative consequences.

Comprehensive awareness training would be necessary to ensure common and consistent understanding about the proper basis for assessment of mental capacity – for service providers 'at street level', for clinicians, lawyers, and in ACAT and the courts.

Concern has also been expressed that if Framework Option C, in its final expression, constituted a more liberal approach to mental health law, more consumers with mental illness might be encouraged to move to the ACT, causing increased demand for mental health resources.

Part III: Other Structural Issues

In describing the optional Framework Options in Part II, a number of the issues that have arisen in the course of the Review (such as issues in relation to risk of harm and mental capacity) that affect the structure of the legislative framework, have been identified and described. Part III summarises other issues in the Review that have particular relevance to the choice of Framework Option for mental health and related law.

The issues include:

- The definitions issue
- Placement of forensic provisions
- Restrictive practices
- Other problems in guardianship

The definitions issue

Diagnosis as a structural element

Issues around the description of the persons eligible for orders under the Act, based on a diagnosis that falls within either the definition of ‘mental illness’ or ‘mental dysfunction’ in the Act, have, in past years of the Review, been hotly debated.

The particular issue of the longer-term detention of people who are mentally dysfunctional groups is described below. More generally however, the debate around grouping and defining populations in legislation according to diagnosis lead some stakeholders to question the purpose and value of that form of distinction as a appropriate structural basis for legislation⁷.

Although the definition of mental dysfunction has been criticised as being too broad, the type and number of community care orders made by the Tribunal over the years has been modest. In 2007–2008 there were only 11 medical applications in the whole year for a CCO (as compared with 284 for PTOs).

This does not mean, however, that consumers with conditions other than mental illness are barely present in the system. In a pilot demographic study conducted over an eight-week period at the Mental Health Tribunal in 2008, certain non-mental illness conditions⁸ appeared in the primary, secondary or tertiary diagnosis of a total of 66% of all clients appearing before the Tribunal. Fourteen percent of clients had a primary diagnosis of a non-mental illness condition. Of these, 40% (six clients) received a PTO at the conclusion of their appearance and only one, a CCO.

It is noted that the criteria for a psychiatric treatment order under the MHA requires that a person ‘has a mental illness’⁹ not that mental illness is the sole or primary diagnosis. Thus, a range of clients with ‘dual disability’ and ‘dual diagnosis’ are eligible for a psychiatric treatment order.

Longer-term detention of consumers with mental dysfunction conditions.

It is notable that amongst Australian jurisdictions, only the ACT includes in its current mental health legislation provisions for longer-term preventive detention of consumers with conditions satisfying the definition of mental dysfunction under the MHA, as well as for consumers with mental illness. The inclusion of this larger group has been criticised as not in accordance with internationally accepted medical standards.¹⁰ If long-term detention does not have significant clinical benefit, it is argued, there is insufficient justification for interference with human rights represented by the detention.

7 AEQUITAS Communications, Stage 2 Consultation Report, April 2008, pg 12.

8 The ‘non-mental illness conditions’ statistically assessed in the trial were cognitive disorders, developmental disorders, substance-related disorders, behavioural disorders, brain injury and intellectual disability.

9 Section 173 MHA

10 Watchirs H. (on behalf of National Rights Analysis Instrument Assessment Panel). 2000.

Application of Rights Analysis Instrument to Australian Mental Health Legislation: Report to the Australian Health Ministers’ Advisory Council, National Mental Health Working Group

Other jurisdictions employ either guardianship orders where long-term detention is required for the person's care and support or court or forensic orders where the goal is to prevent criminal or anti-social behaviour.

Dual disability and dual diagnosis

As noted above, a large proportion of people receiving orders under the MHA have non-mental illness conditions within their diagnostic profile. The Act allows that consumers with dual disability or dual diagnosis may be subject to a PTO, including in cases where a mental disorder that is not a mental illness is the primary diagnosis.

It has been suggested however that a 'psychiatric treatment order' is not the most appropriate description of an instrument for involuntary intervention for a person whose difficulties have been 'primarily diagnosed' as other-than-mental-illness, despite the accompanying presence of, say, a depressive disorder or anxiety condition.

If it were clear that such PTOs were applied only for the purposes of treatment of the mental illness component of a dual diagnosis or dual disability, there would be no arguable concern. It is apparent however, both from anecdotal evidence and by example in the cases reviewed in the demographic pilot, that treatability is not necessarily a feature in these cases.

There are other cases where there is no apparent dual disability or dual diagnosis but where it is considered that the disorder is of such a nature that involuntary care is necessary, or instead that diagnosis has shifted over time (e.g. where the original concomitant mood disorder may have resolved, but the incapacitating dementia remains). In these cases also, it is considered that scope for involuntary detention, care, support continues to be needed.

Preventive detention

Interventions that are preventive in nature include the involuntary assessment orders (conducted either in the community or at the Psychiatric Services Unit), early community-based involuntary treatment, and, lastly, involuntary detention. Understandably, as it involves a significant incursion into individual freedom, focus in Review has been directed to the circumstances under which involuntary detention should be permitted.

There are three views about the relative rights aspects of the application of involuntary detention in particular to consumers with mental illness or mental dysfunction.

One view is that the same rights and protections against incarceration that are available to people who do not have mental illness or mental dysfunction should be afforded to those who do. That is, consumers should not be detained on the basis of what they might do (rather than actually do), or on the basis of an assessed 'risk of harm to others'.

Another view is that the state should retain power to control the behaviour of consumers assessed to be dangerous to their families, carers or to society at large without the need to resort to the use of criminal justice legislation, and that the imperative is particularly strong when the consumer has a mental disorder that it manifestly treatable in the context of detention.

A third view accepts that preventive detention may be justifiable in individual cases, and that protection from prosecution and criminal incarceration may be in the best interests of those individuals.

It is accepted that it is in the co-presence of mental disorder and dangerousness that it is most difficult to balance the rights of the consumer and the rights of the community to live in safety

Regardless of the model adopted, a critical feature for any future scheme will be presence of robust review mechanisms.

Placement of forensic provisions

Who are forensic mental health consumers?

In the ACT, forensic mental health is a term that refers to the area of law and medicine that applies to people with mental health conditions who have engaged in criminal behaviour, whether they are arrested, charged, convicted or found not-guilty. This is consistent with the World Health Organisation standards.

The term forensic patient can also apply to a person receiving mental health treatment who is regarded as a significant danger to their carers and/or the community. In these cases, the person concerned will not necessarily have come to the attention of police or the courts.

Ease of use

The ACT law dealing with forensic patients is currently spread across several pieces of legislation including:

- *Crimes Act 1900*
- *Criminal Code 2002*
- *Mental Health (Treatment and Care) Act 1994*
- *Corrections Management Act 2007*
- *Children and Young People Act 2008*
- *Public Advocate Act 2005*
- *Bail Act 1992*

Stakeholders involved with forensic patients in law enforcement, corrections, the justice system and health services have reported difficulty in finding and using the relevant law because of this fragmentation. The suggestion is for a degree, at least, of consolidation in the location of the forensic provisions.

It is further suggested that consolidation of the forensic provisions would assist the range of service providers involved to more clearly identify and provide for the likely complex needs of the consumer, as well as the security needs of the community, often an issue in forensic cases.

The options in relation to consolidation include gathering the provisions into the general legislation dealing with mental health law or into a special forensic mental health law.

Stigma

Consumers with mental illness and mental dysfunction conditions have significant concerns about the negative societal attitudes encouraged by the co-location of a significant set of provisions dealing with consumers who are offenders, alongside law providing for treatment and care for consumers who have no involvement whatsoever with the criminal law.

Other stakeholders are concerned that forensic consumers are not stigmatised by separate status within the mental health system.

Parity

There is a concern that there should be equivalence in the health services available to forensic patients and ordinary mental health consumers.

Some stakeholders are concerned that the separation of forensic from general mental health law will result in a divergence in the laws and process over time and will result in health or rights disadvantage for the forensic consumers.

Balancing rights and interests

Whilst the general principle of equivalence in rights appears to be well-supported it is also acknowledged that the rights of forensic consumers need to be balanced against the rights of the community to public safety, and the interests of non-forensic consumers. This principle may support the application of considerations, such as risk of harm, differently in the law applying to forensic consumers.

Restrictive practices

What are restrictive practices?

The term restrictive practice refers to all care practices that limit the liberty or autonomy of a person to prevent risk of harm either to the person themselves or to others.¹¹ A restrictive practice is not treatment and there is usually no or little element of benefit for the consumer other than the prevention of harm or effective management.

Restrictive practices may include detention, locked door and window policies, containment or seclusion within a specific area (such as one's room, for 'time-out'), the use of mechanical restraint, such as a belt to prevent injury, the use of chemical restraint to reduce anxiety or control sexual behaviour, and the use of electronic monitoring devices.

Forms of restrictive practice are used, often on a daily basis, in mental health facilities, disability homes, aged care and nursing homes, respite facilities, hospitals and in private homes.

Why are they an issue?

There is currently no scope under the ACT's GA for a guardian to give consent to the use of restrictive practices. The legality of use of restrictive practices in the ACT therefore relies on the ability of the service provider to justify their actions under the common law doctrine of necessity, which would be particularly difficult in circumstances of resistance by the consumer. It is acknowledged that 'trespass on the body' in the absence of informed consent is a fertile and developing field for litigation in Western societies.

Without law that expressly describes the appropriate, legal use of restrictive practices, service providers who engage in them may be at risk of suit for assault, false imprisonment and negligence. Vulnerable consumers, on the other hand, are liable to effects of the unregulated use of restrictive practices, which may be wrongly used for 'sheer convenience or ad hoc utility'.¹²

Other problems in guardianship

Lack of 'coercive powers'

The ACT's GA is an example of the most traditional form of Australian guardianship law which provides that a guardian may perform action that is consistent with the best interests and the wishes of a person with impaired capacity.

The ACT's guardianship scheme does not provide a guardian with legal power to take action or give consent for action that, though it may be in the best interests of a person lacking mental capacity, is refused or resisted by the person. This is referred to as the absence of 'coercive powers' in our guardianship system.

At present, where a person under guardianship requires psychiatric treatment, that treatment can only be provided under a PTO.

11 Victorian Law Reform Commission. 2003. *People with Intellectual Disabilities at Risk: A Legal Framework Option for Compulsory Care – Report*. Accessed on 8 September 2008 from the website of the Victorian Law Reform Commission at www.lawreform.vic.gov.au.

12 Carter, W. *Challenging Behaviour & Disability: A Targeted Response*. 2006. Report - July 2006. Accessed on 8 September 2008 at the website of Disability Queensland www.disability.qld.gov.au/.../positive-futures/documents/investing-in-positive-futures-fullreport.

Most other jurisdictions around Australia have included some provision for coercive powers in their guardianship legislation. Some of the consequences of the absence of these powers in the ACT are described in the following sections.

Alternate sources of authority for coercive treatment for mental dysfunction

If impaired decision-making capacity arises together with risk of harm, and the action proposed is for care or therapy in relation to a person's mental dysfunction, then authority for intervention can be authorised under the mental health, guardianship or power of attorney legislation.

Which to choose? In real terms the choice may be determined by whether or not detention or restraint of the person is required, additionally, to facilitate care. In this case, a mental health order would be the only option as coercive powers are not provided under the other laws.

Treatment of 'non-mental health' conditions

Paradoxically, if detention or restraint is required to facilitate treatment or care other than for the person's mental dysfunction or illness (say, for hospital treatment of encephalitis), there is no power at all (not in the mental health, guardianship or power of attorney legislation) to assist a substituted decision-maker to make the decision that would be in the best interests of the consumer lacking capacity unless the common law doctrine of necessity in the circumstances can be engaged. As noted previously, in the face of outright refusal by the consumer, it is likely that the threshold for necessity would be held to be high.

No regulation or authority for restrictive practices

See 'Restrictive Practices' above.

No psychiatric treatment under guardianship

The ACT's GA currently excludes psychiatric treatment from the scope of health treatments for which a substitute decision-maker under the Act may give consent on behalf of a person who has mental impairment. Involuntary psychiatric treatment was intended to be the realm of the MHA rather than the GA. There is a gap however in that not all consumers who lack mental capacity are being treated in the public mental health system under involuntary orders.

The exclusion of psychiatric treatment from guardianship in the ACT leaves both consumers and clinical service providers exposed to the uncertainties of the common law in the event that a consumer lacks mental capacity to provide consent to treatment. There are no substitute decision-makers who may be authorised to provide consent. The legality of treatment without informed consent (or substituted consent) relies on the doctrine of necessity which may, in certain circumstances be provided in the absence of an emergency. The treatment of 'voluntary' patients who do not possess capacity to consent, at psychiatric facilities and in private care, fall into this area of concern.

Treatment under the Framework Options

Framework Option C, of the three Frameworks, has the most potential to rectify the existing problems with our guardianship scheme because:

- (a) it removes the gaps and overlap at the interface between the mental health and guardianship schemes, and
- (b) it could provide for all contexts of necessary involuntary intervention on behalf of all consumers who lack capacity to provide consent.

Under Framework Options A and B, an enforcement power provided to guardians to enable decisions despite the refusal of a person with impaired decision-making capacity would advance the current position in relation to ensuring needed treatment for general medical treatment and for restrictive practices. The issues in relation to substituted consent to psychiatric treatment would require removal of the prescribed status of psychiatric treatment under the GA.

APPENDICES

Appendix A

*WHO Basic Principles for Mental Health Care Law*¹³

1. Promotion of Mental Health and Prevention of Mental Disorders
2. Access to Basic Mental Health Care
3. Mental Health Assessments in Accordance with Internationally Accepted Principles
4. Provision of the Least Restrictive Type of Mental Health Care
5. Self-Determination
6. Right to be Assisted in the Exercise of Self-Determination
7. Availability of Review Procedure
8. Automatic Periodical Review Mechanism
9. Qualified Decision-Maker
10. Respect of the Rule of Law

Appendix B

A possible formulation of a definition of mental capacity

For the purposes of the Act, a person is unable to make a decision and lacks capacity if unable:

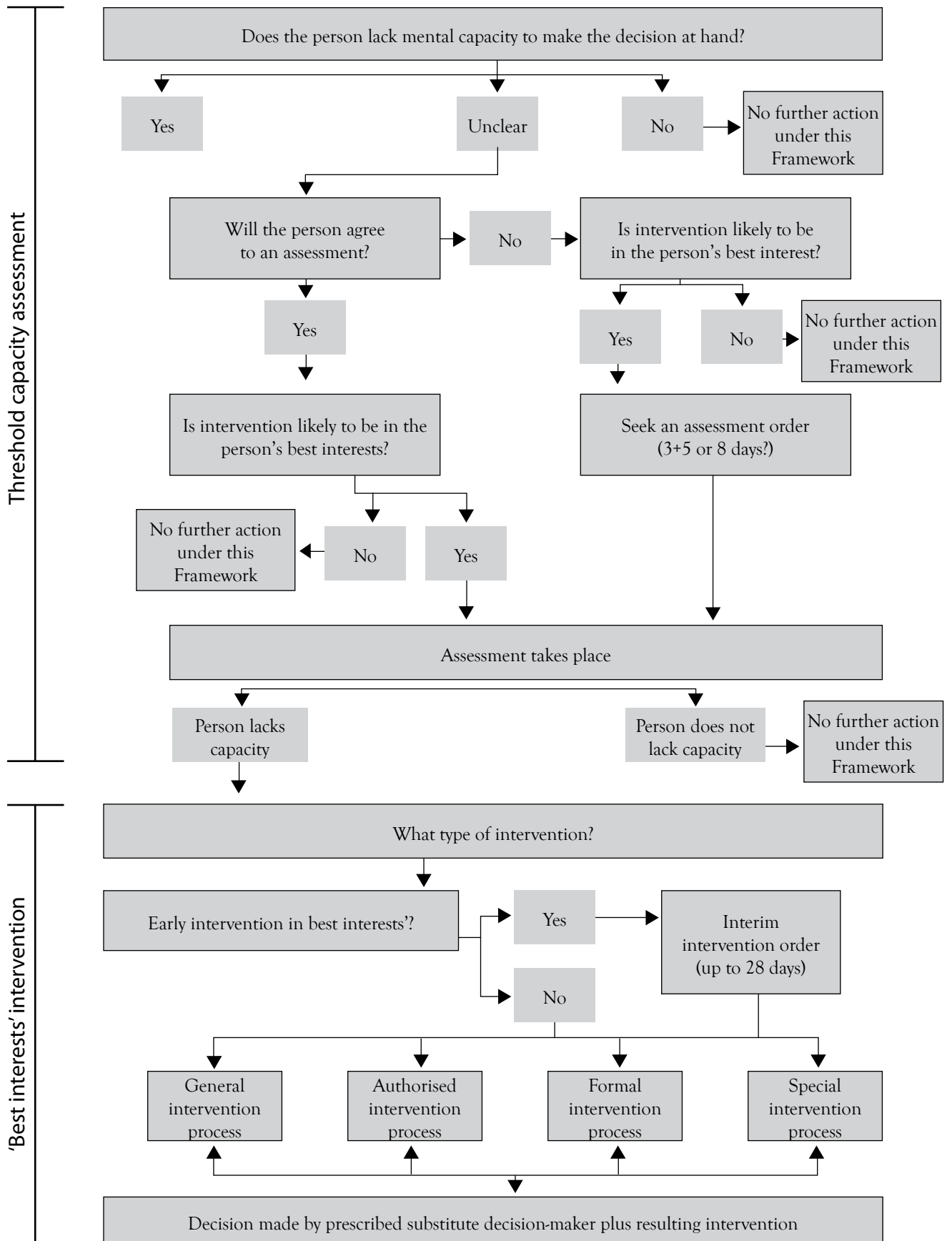
- (a) to understand the information relevant to the decision
- (b) to retain that information
- (c) to use, weigh or appreciate that information as part of the process of making the decision, or
- (d) to communicate the decision (whether by talking, using sign language or any other means)¹⁴.

13 World Health Organisation (1996) *Mental Health Law: Ten Basic Principles*. Accessed on 1 June 2009 from the website of the World Health Organisation at http://www.who.int/mental_health/media/en/75.pdf

14 Based on sub-section 3(1) of the *Mental Capacity Act 2005* (UK). ('Appreciate' requirement added by suggestion in private correspondence G Szmukler, Professor Psychiatry and Society, Kings College, London and consultant M Livermore, April 2009).

Appendix C

Flow diagram - Indicative initial process in an integrated framework for substituted decision-making in the absence of mental capacity.



Appendix D

Indicative considerations - long-term intervention processes

Framework Option C – A Mental Capacity Law

Refer to Appendix B for indicative early and interim process.

	General Intervention	Authorised Intervention	Formal intervention		Special intervention
			Level 1	Level 2	
Coverage	Necessary, day-to-day care and treatment Low-level financial transactions Non-protesting person (not treatment)	Locked-door accommodation Protesting person (for other than treatment) Non-protesting patient for ordinary medical treatment	On-going containment and restraint	Certain prolonged or serious treatment; detention;	Non-therapeutic sterilisation Psychosurgery
Prescribed decision-maker	'Person responsible'	Appointed guardian or attorney (or PA ACT)	ACAT		ACAT or court
Criteria	'Best interests', but list of considerations per level of intervention may include, say:				
	Interventions proposed likely to meet needs of person		Reasonable risk of harm to self or others		
Process			Formal Intervention Plan Formal Intervention Order (up to 6 months) Restriction Order		
Oversight/ Protections					
Appeals	PA ACT? ACAT?	ACAT	ACAT/Court		Sup Court

Appendix E

Research on incidence of mental incapacity

Psychiatric patients

A large UK study found that 60% percent of the total intake (voluntary and involuntary) of psychiatric in-patients assessed lacked mental capacity to make decisions about their treatment. This proportion varied according to diagnosis, ranging from 97% in people with a form of mania, to 4% in people with personality disorder. Mental incapacity was common in patients admitted voluntarily to the psychiatric wards (39%), and in the majority of those involuntarily detained under mental health law (89%).¹⁵

Bellhouse et al¹⁶ also found that only a small number of individuals involuntarily detained under mental health laws in England and Wales retained capacity, and further that many voluntary patients also lacked capacity.

Incapacity in 'medical' in-patients

Another study¹⁷ examined the prevalence of mental incapacity in 'general medical' (i.e. not-psychiatric) acutely-admitted inpatients.

Using a similar form of assessment to the one used by Owen et al in the psychiatric context, at least 40% were assessed to lack mental capacity in relation to treatment decision. It was noted that clinical teams identified that only 25% of patients lacked that capacity. The researchers concluded that mental incapacity is common in acutely ill medical inpatients, and that clinicians tend not to recognise it.

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- 15 Owen, G S, Richardson, G, David, A, Szukler, G, Hayward, P & Hotopf, M. 2008. *Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study*. British Medical Journal 2008;337:a448 (June 2008). Accessed on 9 October 2008 at http://www.bmj.com/cgi/content/full/337/jun30_1/a448.
- 16 Bellhouse, J, Holland, A, Clare, JCH, Gunn, M., Watson, P., 2003 *Capacity-based mental health legislation and its impact on clinical practice: 1) Admission to hospital Journal of Mental Health Law 9:9-23 and 2) treatment in hospital*. Journal of Mental Health Law 9, 24-28.
- 17 Raymont, V, Bingley W, Buchanan A, David AS, Hayward P, Wessely S, Hotopf, M. 2004. *Prevalence of mental incapacity in medical inpatients and associated risk factors: cross-sectional study* Lancet, 2004 Oct 16-22;364(9443):1421-7. Accessed on 9 October 2008 from the PubMed website at <http://www.ncbi.nlm.nih.gov/pubmed/15488217>.

Feedback Form

Please feel free to use this form to provide feedback to the ACT Government on the 'Framework' Options Paper. Alternatively, you may prefer to make your comments by email to the address below or in a separate written submission.

All feedback will be collated and provided to the cross-sectoral Review Advisory Committee (RAC) and will contribute to the next phase in the development of the revised law.

Optional Information

Name

Organisation/Agency

Date

1. Should there be a standardised definition of mental capacity for use within the framework of mental health law and related legislation? What are your views about the appropriateness of a definition based on the 'domains of capacity', of the type set out at Appendix B?

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2. What are your views, generally speaking, about the placement of provisions for involuntary provisions for people with mental dysfunction conditions? Should they be in mental health legislation, in guardianship legislation, or perhaps nowhere at all?

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3. Should substituted decision-makers (such as guardians and the Tribunal) have power to enforce decisions in the best interests of people who lack capacity under guardianship law, even in circumstances when those decisions are resisted by the person with impaired capacity?

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4. Which of the three Framework Options proposed in the Paper do you prefer and why?
Considering the possible variations listed in the Paper for the Framework Option you have chosen, which variations should be applied (if any)?

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5. Do you consider that the issues raised in the Paper in relation to the ACT's guardianship legislation are important and need to be addressed?

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6. Do you think that the issues raised in the Paper in relation to restrictive practices should be addressed?

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7. Any other feedback or comments you want to provide?

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Thank you for your contribution.

Please forward submissions by 29 January 2010

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