



**Submission:**

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

Submitted via email to:

Mentalhealth.policy@act.gov.au

By:

ACT Mental Health Consumer Network Inc.

The Griffin Centre, Level 2, Room 11

20 Genge Street, Canberra City, 2601

P.O.BOX 469, Civic Square, ACT, 2608

Phone: 02 6230 5796 Fax: 02 6230 5790

Email: [policy@actmhcn.org.au](mailto:policy@actmhcn.org.au)

Website: [www.actmhcn.org.au](http://www.actmhcn.org.au)

On: 2 October 2012

## **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 First 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 has participated in the consultation process leading up to the release of this Exposure Draft. We acknowledge that the Health Directorate has sought to develop these amendments in a consultative manner, and to take into account the views of stakeholders, including mental health consumers.

We also acknowledge and appreciate the effort that has been taken to enable participation in this consultation, through the materials and the availability of officials to discuss the changes, as well as the various means of providing comments. In particular, the inclusion of a mock up of the amended Act greatly assists in understanding the effect of the proposed changes. We thank the Health Directorate and the Parliamentary Counsel's Office for providing the mock up. It is a shame that its utility is reduced, somewhat, by including the renumbering of the Act in the mock up, which makes it very difficult to move between the Explanatory Statement, Exposure Draft and the mock up. This submission refers to sections as they are numbered in the Exposure Draft, before renumbering.

We are pleased to see that the Exposure Draft includes many of the changes recommended by the Review Advisory Committee. However, there are a number of areas in which we believe the Exposure Draft falls short of what was intended. We consider that with the changes in the Exposure Draft, the Act and the mental health system operating

under it will still fall short of an acceptable recognition of the human rights of mental health consumers.

Before commenting on the specific provisions of the Exposure Draft, we note the widespread view that involuntary hospitalisation and involuntary treatment contravene article 14 of the Convention on the Rights of Persons with Disabilities, as well as article 17. They also constitute discrimination. Where no crime has been committed or alleged, involuntary hospitalisation is a form of preventative detention that does not apply to other members of the community who are not considered to have a mental illness but who may well pose a risk of harm to others. We are aware that there is no political will in the ACT at this stage to completely remove the ability for people with mental illness to be involuntarily detained and medicated, forcibly if that is considered necessary. However, these are extreme limitations on a range of human rights. If these limitations are to remain in place, then it is critical that they be able to be lawfully applied only where there is no other option that can safely be used.

It is also critical that the Act be sufficiently precise and intelligible to enable consumers to exercise their rights under it, and to be accurately applied by treating teams and hospital authorities. To that end, we recommend a number of drafting changes to clarify what currently appear to be ambiguous or unclear provisions.

## **RECOMMENDATIONS:**

- 1. Amendments to the Act should be accompanied by a sufficiently resourced program of education and information about the changes, focusing on the rights of consumers. Consumers should be part of the development and delivery of the education and information program, which should be provided on an ongoing basis to a wide target audience.**
- 2. The new Chapter 8, Rights of people with mental dysfunction or mental illness, should be moved to become new Chapter 3, before provisions about limiting or abrogating consumers' rights.**
- 3. The Act should:**
  - establish a presumption that applies to all actions and decisions that a person with mental illness has decision making capacity, unless it is established that they do not;**
  - include a set of criteria for the assessment of capacity; and**
  - ensure that the possibility that the person may not have capacity in the future is not a basis for considering that they do not have capacity at the time of assessment.**
- 4. The Act (new section 28) should provide that the ACAT may make a mental health order authorising treatment of a person who has capacity to consent to the treatment but refuses to consent only in exceptional circumstances where the risk of serious harm to that person or another is both high and imminent.**
- 5. References to 'Reasonable judgment' in new sections 9C, 9D and 10 should be replaced by references to decision making capacity.**

- 6. New s.53D should be amended to include, in the possible contents of an Advance Agreement, whether or not the person consents to specific treatment or medications. The decision not to consent should be binding on anyone involved in making a decision about, or administering, treatment, care or support of the person with an AA.**
- 7. S.53H, s.53I and s.53L should be amended so that a guardian or person acting under power of attorney is bound by an AA, at least to the extent that it expresses clear consent or lack of consent to treatment.**
- 8. The Act should make clearer the extent of membership of a treating team and whether the membership changes over time.**
- 9. S.139B should be amended so that the membership of the Mental Health Advisory Council includes both a consumer and a carer. There should be no caveat of reasonable practicability on the appointment of a consumer to the Council.**

## Specific Comments

If these amendments are to effect a change in culture within the mental health system, to promote a Recovery focus and to provide the greatest possible respect for the human rights of people who are affected by its operation, then they will need to be accompanied by effective information and education. There will need to be a number of target groups, including mental health consumers and their advocates, carers, psychiatrists, doctors and mental health services and potential members of treating teams. Education should not be one off, but needs to be delivered on an ongoing basis, both before and after commencement of the new provisions. Information and education materials should be developed in consultation with consumers, who should also be involved in their delivery.

- 1. Amendments to the Act should be accompanied by a sufficiently resourced program of education and information about the changes, focusing on the rights of consumers. Consumers should be part of the development and delivery of the education and information program, which should be provided on an ongoing basis to a wide target audience.**

## Structure of Act

While efforts have been made to provide greater recognition of the human rights of people with mental illness or mental dysfunction, the structure and language of the Act focus on what can be done to people, rather than how best to support their rights.

We suggest that if the Act is intended to promote a Recovery focus, then the Act itself should focus first on rights, and then on the ways in which it allows the rights of individuals to be limited or abrogated. At minimum, the new Chapter 8 should be moved so that it becomes Chapter 3. This is an important change for consumers, mental health professionals and others to reinforce the messages of the Objects and Principles.

**2. The new Chapter 8, Rights of people with mental dysfunction or mental illness, should be moved to become new Chapter 3, before provisions about limiting or abrogating consumers' rights.**

## **Decision Making Capacity**

We are pleased that the Exposure Draft inserts decision making capacity as a criterion when the Administrative and Civil Appeals Tribunal (ACAT) is considering making mental health orders.

However, we have a number of concerns about the way in which the Exposure Draft deals with decision making capacity.

*Principles:* The Exposure Draft inserts a set of 'Principles of decision-making capacity'. We agree with the intention of these principles, and that they should be applied. However, it is not clear to whom the principles will apply, in practice, as it is not clear who will be making assessments of a person's decision making capacity.

Rather than being determinative, the principles must be 'taken into account'. This is insufficient recognition of the principles, which should instead be applied by the Act. New paragraph 9(1)(a), in particular, should be a presumption of capacity that applies to all actions and decisions under the Act, as a start point, not just taken into account when decision making capacity is being 'considered'.

In addition, the lack of any guidance on the criteria to be applied to determine whether a person has the capacity to consent to treatment, care or support leaves it open to wide variation in how capacity is assessed, in practice. We do not propose that the Act require specific methodology. It should, however, set out criteria by which decision making capacity is to be determined.

We agree that capacity may change over time. However, the possibility that a person who currently has the capacity to consent or not to treatment may not have that capacity in the future should not result in a person being effectively deemed not to have capacity at the time this is being considered. If the basis for overriding the decision of a person who has capacity is that the person may not have capacity in the future, this should be limited to

circumstances where there is a high probability that they will not have capacity in the very near future. In addition, rather than deeming the person not to have capacity, the expectation that they will not have capacity in the near future should be clearly stated.

**3. The Act should:**

- **establish a presumption that applies to all actions and decisions that a person with mental illness has decision making capacity, unless it is established that they do not;**
- **include a set of criteria for the assessment of capacity; and**
- **ensure that the possibility that the person may not have capacity in the future is not a basis for considering that they do not have capacity at the time of assessment.**

*Role of capacity in deciding whether to make orders:* It was the clear view of the working group considering this issue that the Act should provide for a capacity assessment and process first and then consider risk afterwards. The working group was also clear that the outcome of the capacity-based assessment should only be 'over-ruled' by the risk assessment in cases of over-riding/exceptional risk. We do not consider that this has been achieved in the Exposure Draft. The criteria for making psychiatric and community care orders need to be revised so that where a person has refused to consent to the proposed treatment, and has the capacity to make that decision, an order can be made only where the risk of serious harm to that person or another is both high and imminent.

**4. The Act (new section 28) should provide that the ACAT may make a mental health order authorising treatment of a person who has capacity to consent to the treatment but refuses to consent only in exceptional circumstances where the risk of serious harm to that person or another is both high and imminent.**

*Extent of consideration of capacity:* The amendments insert decision making capacity as a criterion, albeit a weak one, to be considered by the ACAT when considering whether to

make mental health orders. However, decision making capacity has not been adequately integrated into the scheme established by the Act.

The criteria for making an application for an assessment order, in new sections 9C and 9D, refer to the person's ability to 'make reasonable judgments'. The use of a different standard here is confusing. It also undermines the integration into practice of the assumption of decision making capacity and the need to consider supported decision making. The criteria for assessment orders should not apply a different standard for decision making ('reasonable judgment'), but should be based on whether the person has relevant decision making capacity.

**5. References to 'Reasonable judgment' in new sections 9C, 9D and 10 should be replaced by references to decision making capacity.**

## **Emergency Detention**

We are very pleased to see the inclusion of provision for ambulance officers to provide emergency transport to hospital for mental health consumers. This is a welcome recognition that police intervention should be a last resort. We look forward to implementation of this measure so that the focus is on a health rather than policing approach to people in crisis.

We note, however, that a person without a health concession card may be required to pay a significant cost for being transported in an ambulance. We do not consider that a person who is detained and transported under this Act should be required to pay the cost of that transport if it is by ambulance.

There should be provision to ensure that no one transported by ambulance under the amended Act should have to pay for that transport.

There are very mixed views among consumers about allowing the ACAT to order a longer period of emergency detention. As indicated in the Explanatory Statement, the 18 month period of review of this provision is critical. The Network will be keen to see the data on

whether there is a reduction in applications for longer term orders where longer periods of emergency detention are authorised. We also note that new s.41(2) enables the chief psychiatrist to apply for an extension of emergency detention only where the chief psychiatrist believes on reasonable grounds that the person does not have relevant decision making capacity.

## **Advance Agreements**

We are pleased to see the recognition of Advance Agreements (AAs). The Network believes that the ability of a person who has decision making capacity to nominate, in advance, that they do or do not consent to certain treatment, is an important recognition of the individual's human rights. Further, the ability to set out wishes and preferences so that these can be acted upon at a time when the consumer may not be able to communicate those wishes and preferences is an important step forward in activating a Recovery approach.

However, the drafting of these provisions is not clear and leaves a number of ambiguities.

First, 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 nominated 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, new s.53D, in setting out the possible contents of an AA, refers to a person's wishes and not to consent in relation to treatment, and specifies that the AA can include whether the person consents only in relation to seeking views from family members or carers. This makes it unclear what the status of 'wishes' is, but could imply that a person cannot specify in an AA that they do or do not consent to particular treatment.

**6. New s.53D should be amended to include, in the possible contents of an Advance Agreement, whether or not the person consents to specific treatment or medications. The decision not to consent should be binding on anyone involved in making a decision about, or administering, treatment, care or support of the person with an AA.**

At present, s.53H has the effect that a person, presumably other than a mental health professional, making a decision about treatment, care or support must consider the advance agreement, but is not bound by it. Mental health professionals administering treatment, care or support are bound by the AA, subject to an order from the ACAT. In our view, a guardian or person with power of attorney should also be bound by the AA.

**7. S.53H, s.53I and s.53L should be amended so that a guardian or person acting under power of attorney is bound by an AA, at least to the extent that it expresses clear consent or lack of consent to treatment.**

We understand that the definition of 'mental health professional' is broad enough that people working in community services and other non-ACT Government employees may be part of the treating team, but we would be grateful for confirmation that this is the case. If so, is it possible for a person to make an AA with, for example. members of a community service and a psychologist, which would then be binding on ACT Health staff should the consumer be admitted to hospital?

AAs rely on the concept of an agreement between the consumer and the 'treating team'. However, it is not clear who would constitute the treating team at various times. For example, if a consumer wishes to amend their AA, it appears that the treating team who must agree, under s.53F, may include people who were not part of that team at the time the AA was signed off. Conversely, we assume that a former member of the treating team who is no longer involved in treatment is not required to agree, but it is not clear if that is the case.

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 the definition be clarified.

**8. The Act should make clearer the extent of membership of a treating team and whether the membership changes over time.**

We also understand that it is proposed to amend the provisions so that a person may not withdraw their AA at a time when they do not have the capacity to make that decision. We are pleased that this change will be made, as many consumers have noted that this would have undermined the value of an AA considerably.

## **Review**

We are also pleased that the extension of Emergency Detention period and the criteria for making mental health orders will be reviewed and that a time limit has been provided for reporting on these reviews.

## **Forensic orders**

We are pleased to see much greater clarity around forensic orders. As far as possible, the requirements for authorising involuntary treatment should mirror those for non-forensic orders.

We note that new Part 6.2 provides for information about a person to whom a forensic mental health order is in place to be shared between different entities. We assume that these entities are those listed under 'information sharing protocol' in new s.101, as that line appears to have been inserted in the middle of the definition of 'information sharing entity'.

The Network agrees that lack of appropriate information sharing can lead to poor outcomes for consumers. We agree that new s.102(2) provides an appropriate limitation, so that only information reasonably necessary for safe and effective care will be shared. We agree that it is desirable that the relevant agencies develop information sharing protocols to provide the details of information sharing arrangements. However, the new provisions will enable information sharing even if the person the information is about does not consent to it being shared. We therefore strongly suggest that consumers and carers should be consulted in developing any information sharing protocols under these provisions.

### **Mental Health Advisory Council**

We are pleased that the Act is to provide a statutory basis for the Mental Health Advisory Council and that the Council is given broad scope to advise the Minister. We suggest that the Council's functions could be improved by enabling the Minister to seek advice on a specific matter relating to mental health.

*Membership:* New s.139B(2) provides for the range of expertise to be included in the Council's membership. The Network does not agree that it is appropriate that this should include *either* a consumer or a carer. Rather, the Council should always include both a consumer and a carer; that is, s.139B(2)(a)(i) and s.139B(2)(a)(ii) should not be alternatives. In addition, the caveat 'unless it is not reasonably practicable' should not apply to the requirement to appoint a consumer.

**9. S.139B should be amended so that the membership of the Mental Health Advisory Council includes both a consumer and a carer. There should be no caveat of reasonable practicability on the appointment of a consumer to the Council.**

We would be happy to discuss any of these comments and recommendations, and look forward to the next draft.